

**THE INSTITUTIONALISATION OF THE AGED;
THE IMPORTANCE OF VISITATION, AND
THE ROLE OF THE SPECIALISED VISITOR**

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“DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

ABSTRACT

Ageing is a fact of life. It often gives rise to unfortunate consequences. Physical infirmities; senile dementia; emotional disturbance. Indeed, the effects of the ageing process can be such as to render a person incapable of performing the ordinary and normal functions of life. In such a case, institutionalisation presents itself as a prospect to enable an aged person to cope with the ordinary day-to-day activities of living.

The purpose of institutionalisation is to improve the quality of life of the elderly. In considering the process, a number of important facets need to be borne in mind. Firstly, the process must be seen in relation to the condition of the person being institutionalised. Secondly, the process must be seen as a matter of extraordinary change in the life of the aged person. This implies a detailed explanation and full disclosure of the process envisaged, and, if needs be, appropriate counselling of the person concerned. Thirdly, there must be sympathetic and sensitive assistance given to the aged person in adapting to a new situation. Fourthly, a continuing and intimate interest in, and concern for, the aged person on the part of the family must be accentuated and impressed.

This gives rise to the importance of visitation on the part of the family. Its meaning and purpose must be understood. The need for meaningful visitation must be stressed, and the status of a respected member of the family must be emphasised. The aged person must never be cut-off, separated or neglected. Visits must not be a coincidental, haphazard and aimless occurrence. Visitation must always be directed at improving the quality of life of the aged person.

The aged person, despite her advanced years and debilitated condition, remains a person with thoughts, feelings, emotions, difficulties and problems. She needs time and attention. The normal or regular pattern of visitation does not, by and large, accomplish these ends. Something more is required. Specialised visitation. This is something different from ordinary, normal, social visitation. It is more intense, more concentrated and more regular. It embodies consistent and continuous contact. It is directed at effectiveness. It is never haphazard or aimless and always has as its objective an improved quality of life for the aged. The specialised visitor and the resident come to know each other well; they come to trust each other, and they come to realise that the object of the visit is more than an exchange of frivolities.

Specialised visitation manifests a concern for the aged; it offers them support, stability, certainty and security. This is so because the specialised visitor responds to an inner conviction, an infinite calling, and an earnest urging. It is not a task but a vocation.

Many factors contribute to the enhancement of the quality of life of the elderly : three may be mentioned. Institutionalisation, visitation and the role undertaken by the specialised visitor.

OPSOMMING

Veroudering is 'n gegewe feit wat dikwels tot ongelukkige toestande soos fisiese swakhede, seniliteit en emosionele versteuring lei. Die gevolge van veroudering kan inderdaad 'n persoon verhinder om die alledaagse en normale funksies van lewe uit te voer. In sulke gevalle bied institusionalisering die moontlikheid dat 'n bejaarde persoon wel kan handel met die gewone dag-tot-dag aktiwiteite van die lewe.

Die doel van institusionalisering is die verbetering van die kwaliteit van lewe van die bejaarde. In die beskouing van hierdie proses moet 'n aantal fasette in aanmerking geneem word. Eerstens, moet die proses in verhouding tot die toestand waarin die persoon wat geïnstusionaliseer word verkeer, gesien word. Tweedens, die proses verteenwoordig 'n buitengewone verandering in die lewe van die bejaarde persoon. Om dit te vergemaklik moet 'n gedetailleerde verduideliking en volle openbaarmaking van die proses wat voorlê aan die persoon gegee word en, indien nodig, toepaslike berading aan die persoon verskaf word. Derdens, die persoon moet simpatieke en sensitiewe bystand in die proses van aanpassing tot die nuwe situasie verleen word. Vierdens, die gesin van die persoon moet baie duidelik onder die indruk gebring word van die belang van voortgesette en intieme belangstelling in die persoon deur hulself.

Hierdie aspek bring die belangrikheid van besoek deur die gesin na vore. Die betekenis en doel van besoek moet deeglik verstaan word. Die behoefte van betekenisvolle besoek moet benadruk word en die status van die persoon as gerespekteerde lid van die gesin beklemtoon word. Die bejaarde mag nooit afgesny, afgesonder of verwaarloos word nie. Besoeke mag nie toevallig, planloos en doelloos geskied nie. Besoeke moet altyd gerig wees op die verbetering van die kwaliteit van die lewe van die bejaarde.

Ten spyte van haar gevorderde jare en afgetakelde toestand bly die bejaarde persoon iemand met eie denke, gevoelens, emosies, moeilikhede en probleme. Sy benodig tyd en aandag. Die gewone of gereelde patroon van besoek bereik oor die algemeen nie hierdie doeleindes nie. Iets meer word vereis, naamlik gespesialiseerde besoek. Dit is duidelik verskillend van die gewone, normale sosiale besoek. Dit is meer intensief, meer gekonsentreerd en meer gereeld. Dit beliggaam bestendige en deurlopende kontak. Dit is gerig op doelbereiking. Dit is nooit planloos of doelloos nie en het altyd as oogmerk om die kwaliteit van lewe van die bejaarde te

verbeter. Die gespesialiseerde besoeker en die inwoner leer mekaar goed ken sodat hulle mekaar vertrou, en besef dat die oogmerk van die besoeke meer behels as 'n uitruil van beuselagtighede.

Gespesialiseerde besoek druk 'n besorgdheid vir die bejaarde uit. Dit gee aan hulle ondersteuning, stabiliteit, sekerheid en sekuriteit. Dit is so omdat die gespesialiseerde besoeker vanuit 'n innerlike oortuiging, 'n onbegrensde roeping en 'n ernstige lewensdrang optree. Dit is nie 'n taak nie maar 'n roeping.

Baie faktore dra by tot die verhoging van die kwaliteit van lewe van bejaardes. Drie hiervan is institusionalisering, besoek en die rol wat die gespesialiseerde besoeker onderneem.

DEDICATION

This work is dedicated to the Management, Administration and residents of the Ladies Christian Home.

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PROLEGOMENA

A. INTRODUCTION

Before proceeding with a consideration of the introduction to the various matters raised in this investigation, it is deemed desirable to reflect upon certain aspects which are cardinal to the work as a whole. The first relates to the underlying reason or logical basis for the research. The second relates to the methodology employed in the investigation. And the third relates to a contextualisation of the way care was given to the aged, and of the general social situation of Cape Town that explains why there was a need for a home such as the Ladies Christian Home.

B. RATIONALE

The question arises as to why time and effort should be expended on investigating the quality of life of the aged and the means whereby that quality of life can be enhanced.

The answer lies in the fact that the ageing of populations is a world-wide phenomenon of the twentieth century. This is certainly true of developed countries, where population ageing has evolved gradually as a result of improving living standards of the majority of the population over a relatively long period of time after the industrial revolution. Technological breakthroughs in the field of medicine, including the development of new and effective drugs and vaccines have contributed to this process. According to projections of the United Nations,¹ the proportion of older persons (aged 60 and over) in the developed regions increased from 11,7 percent in 1950 to 19,1 percent in 1998. By the year 2050, these regions will have a very old population, with the proportion of older persons projected to increase to 32,5 percent.

It is also true of developing countries including South Africa, where the proportion of older persons increased from 6,4 percent in 1950 to 8 percent in 1998. By 2050 the proportion of older persons in these regions is projected to increase threefold to 20,6 percent. The United Nations estimates that the population aged 60 and over in the developing regions will

¹ Department for Economic and Social Information and Policy Analysis. 1994. New York. Ageing and the Family

multiply more than nine times from 171 million in 1998 to 1594 million in 2050. On average, this translates into an additional 2,28 million people being regarded as aged every month during the 1998 – 2050 period.

It is estimated that the costs of global ageing will be far beyond the means of even the world's wealthiest nations, unless retirement benefit systems are radically transformed. Indeed, it is suggested that a failure to do so, to prepare early and boldly enough, will spark economic crises that will dwarf the recent meltdowns in Asia and Russia.²

What more need be said in answer to the question? Population ageing is a demographic reality. World-wide the elderly population is growing both in relative and in absolute numbers. It is therefore of the utmost importance that governments, NGOs, donor organisations, especially in developing countries such as South Africa, must recognise population ageing as a demographic reality and start planning accordingly.³

C. METHODOLOGY

It must be borne in mind that this work, initially, was not conceived as an academic exercise. No problem presented itself; no hypothesis was formulated to meet the problem; there was no experimentation with the hypothesis; nor was there any verification of the hypothesis. It was initiated, implemented and developed as a visitation programme, aimed at enhancing the quality of life of the elderly.⁴ It was, by nature and intention, the rendition of a service, which took upon itself the form of a specialised variety of visitation. It was during the implementation of this programme of specialised visitation that facts emerged, observations were made, inquiries were raised and conclusions were reached that inspired the researcher, in his discharge of the role of a specialised visitor, to enlarge his vision and to embark upon a course of study that may prove to be more helpful.

It is important to appreciate this aspect of the matter. Under normal, or rather, usual, circumstances, the researcher, adopting an objective viewpoint, would apply the scientific method in an attempt to resolve the problem under investigation. He may adopt a

² See: *Population Ageing: A Demographic Reality for South Africa* by Dr Bärbl Haldenwang: UAPS/UEPA Third African Population Conference: Durban, South Africa 6-10 December 1999 p. 129. See also: *Aging and Old Age* by Beth B. Hess and Elizabeth W. Markson (MacMillan Publishing Co. Inc. New York) (1980) at p.6 and 152 ff.

³ See: *Population Ageing: A Demographic Reality for South Africa* (supra. at fn 2.)

⁴ See: Chapter 2.4

quantitative or qualitative approach, or both, in his endeavour to verify the hypothesis he has formulated. Moreover, to verify the hypothesis on a wide scale, he may engage in comparative study. In other words, the end result evolves out of a process of systematic and scientific study.

This did not happen in the instant case. The researcher engaged himself in his research while he was operating as a specialised visitor, and it was, during the execution of this function that he collected his information. This was not by way of intention or design; nor was it in accordance with a pre-determined plan. The method evolved out of a need to construct a guideline for specialised visitation, and in the absence of readily available information or knowledge on specialised visitation, the specialised visitor fulfilled the dual role of specialised visitor and researcher.

The researcher was, in fact, an observer who participated under the guise of a specialised visitor in the observed situation. As such he engaged in participant observation,⁵ his approach being a qualitative one.⁶ Whereas the usual method would commence with investigative study and culminate with a rendition of a particular service, in the instant case, the starting point was the rendition of a particular service, in the form of specialised visitation, and the culmination was in the form of academic study.

A comparative study was not undertaken. The investigation was confined to the Ladies Christian Home by reason of the connections between the researcher and the Home. An in-depth case study was undertaken examining, in turn, the social structure and social function of the Home, as well as its administration. The matters relating to the process of institutionalisation were confined to the Home and all the residents visited resided at the Home. The many facets of visitation manifested themselves at the Home, and all observations relating to the visitor were made at the Home. Likewise, the observations which gave rise to the various conclusions and recommendations were made at the Home.

⁵ See: Hess and Markson: *Aging and Old Age* (*supra* at fn 2.) at p. 24 and 330; Earl Babbie Johann Mouton: *The Practice of Social Research* (Oxford University Press) 2001 at p. 56 and 293.

⁶ See: Earl Babbie Johann Mouton (*supra* at fn 5.) at p. 53.

The case study method, which is a recognised mode of investigation,⁷ was followed with great diligence and care and covered a wide range of social interaction. It is respectfully suggested that the absence of comparative study does not materially affect the outcome of the investigation.

D. CONTEXTUALISATION⁸

The circumstances which gave rise to the founding of the Ladies Christian Home are set out in the next chapter.⁹ The question that arises is: in what way was care given to the aged, and what was the general social situation of Cape Town which gave rise to a need to found a home such as the Ladies Christian Home?

The records in the possession of the General Manager of the Home are instructive.¹⁰ These records deal with the admissions to the Home during the first twenty-five years of its existence. Miss Loftier was the first admission to the Home. She had “no relatives here and none elsewhere in a position to assist her; she has no settled income, her personal wants are provided for by friends”.

Mrs Truter was admitted to the Home in February 1877. She had “no near relatives. Her income is about £50 per annum. She contributes £25 yearly to the Home.” Miss Hoffman was also admitted to the Home in February 1877. She received “from the St. George’s Church and also from the old woman’s fund. She contributes to the Home 8/6 monthly. She is entirely without relatives.” Miss Vervoort was admitted in May 1877. She received “from the old woman’s fund, she gives 3 shillings to the Home monthly.” Miss Hanke had “a small income from the old woman’s fund. She gives 2/6 per month . . . She is without relatives.” She was 80 years of age when admitted.

“Mrs Tier has no near relatives and no home . . . She receives a very small income and gives 2/6 monthly to the Home.” “Mrs Poag has no relatives who can support her and has no income, therefore gives nothing to the Home. £10 has been paid by Mr Theytal for her

⁷ See: *Earl Babbie Johann Mouton* (supra at fn 5.) at p. 280.

⁸ See: *Earl Babbie Johann Mouton* (supra at fn 5.) at p. 282.

⁹ See: *Chapter 1.1*

¹⁰ See: *Admissions Book: February 1877 to 1900: Volume No. 816*

burial expenses.” “Miss Horak has no relatives who can afford to support her so she has been admitted to the Home . . . Miss Horak passed away on Sunday morning . . . after many weeks of suffering and weakness, during which time she frequently expressed her readiness to go . . .” “Miss Bibby has come into the Home from Hospital where she was for some time compelled to remain on account of delicate health. She has no relatives and no means . . . She had been a great sufferer for years, for the last four months was quite confined to bed.” “Miss v.d. Spuy has no nearer relative than a nephew, with whom she had been residing, but in consequence of his marriage she was without a home. She has been admitted to the Home on condition that she would assist in nursing the sick . . . It was found that Miss v.d. Spuy is not equal to the fatigue of assisting in nursing. She is now in the Home on the same terms as the other inmates, and will give a small contribution to the funds.”

“Mrs Smith of Mossel Bay entered the Home . . . she has had several attacks of Rheumatic fever, which have left her quite an invalid. She is without means, and without relatives able, in any way to assist her. A daughter and a family of children (and is in poor circumstances) resides in Cape Town.” “Miss de Villiers having lost her income through the failure of the Bank has been admitted into the Home . . . She contributes 12/- a month . . .” “Mrs Reid (who was sixty nine years of age) entered the Home . . . She is entirely without relatives and income . . .” “Mrs Niepoth has no income. She receives help occasionally from her brother at Riversdale.” She was 83 at the time of admission but, after a short illness, died at the age of 84 years.

At the other end of the scale, Miss de Vries came from the Good Hope Seminary ill with fever. She rallied slightly at first, but, in about 3 weeks died of disease of the heart. She was only fourteen.

These admissions to the Home could be multiplied and more instances could be cited. Suffice it to say that there appears to be a theme which is common to most, if not all, of the cases. Each concerned an elderly lady (save for the child of fourteen) in need of compassionate caring. Each concerned an elderly lady who was struggling in desperate financial circumstances. Each concerned an elderly lady who was left to face the future alone, apparently without relatives or friends, and desperately in need of a home.

This narrative expressed in a few lines tells much of the way care was given to the aged, and paints a picture of the general social situation of Cape Town which gave rise to a need to found a home such as the Ladies Christian Home.

E. CONCLUSION

In concluding these prolegomena, three observations stand to be made in broad general terms. The first relates to the central thrust of the investigation. It is concerned with the aged and the ageing; it is concerned with the quality of life of such people; and it is concerned with ways and means to enhance this quality of life. Not the least aspect of this observation is that, proportionately speaking, the elderly population is not likely to diminish or decrease. The opposite is true, in that, in both developed and developing countries, marked increases in the proportion of elderly people are likely to manifest themselves. Accordingly, it behoves all who are engaged in the upliftment of society, to recognise this development and act accordingly.

The second observation relates to the nature and extent of the investigation. The investigation took the form of an in-depth case study of all the various facets of the Ladies Christian Home related to the lives and conduct of its residents by the researcher who engaged in participant observation while involved, as a specialised visitor, in a programme of specialised visitation. What transpired was, in fact, academic research in reverse, that is to say, not in accordance with the usual research procedures, but arising out of the establishment of a visitation programme. This programme gave rise to problems and difficulties which could only be resolved by adopting a qualitative approach to an academic investigation, in which the researcher was the specialised visitor.

The third observation relates to the facts and circumstances which gave rise to the founding of the Ladies Christian Home. The cardinal aspects of this observation are three-fold. One is "the sad condition of elderly ladies". The second is "reduced circumstances". And the third is "the great need (for a home)". These are the primary factors that gave rise to the foundation of a home which has survived more than twelve-and-a-half decades of time. Obviously, manifold changes have taken place during this period; changes to the structure, changes in the operation, function and administration of the Home, changes in the key

personnel, boards of trustees and emphases, changes to the Constitution. The passage of time, necessarily, involves change and brings about innovations. The question that arises is: to what extent has the effluxion of time brought about a departure from those factors which motivated the founders to establish the Ladies Christian Home?

The answer that emerges from the investigation, with clarity and conviction, is that the quality of life of elderly ladies is not only still the prime concern of the Home, but allied to that concern is a desire to bring about an enhancement of their quality of life. Likewise, the frustrations of debilitating vagaries of adverse economic trends have not dimmed the vision to have a healthy and compassionate regard for those whose “circumstances are reduced”. As it was in the beginning, so is it now: there is a great need for a home such as the Ladies Christian Home, a need which is not likely to diminish or decrease, but rather, increase, demanding that wise and adequate preparations be made in the interests of those who may, effectively, not be able to care for themselves.

The prolegomena having been considered, attention is now directed at the introduction to the investigation.

SECTION A. INTRODUCTION**Chapter 1. THE BACKGROUND, INTRODUCTION AND APPROACH TO THE INVESTIGATION****1.1 Background**

The Ladies Christian Home was established in Cape Town in 1876. The purpose of the founders was to provide a Home for aged and indigent Ladies.¹ The impetus which led to the founding of the Home came from a sense of the great need that existed. Mrs Lion Cachet, the wife of a Dutch Reformed Church Minister, in her visits among the poor, was concerned with the sad condition of elderly ladies living in reduced circumstances. She addressed her concern to the Christian Conference which was meeting in Cape Town in March, 1876. Her appeal took the form of a letter in which she stressed the need for a home such as those she had seen overseas.

At a meeting held at the South African Mission Chapel on the 11th March, 1876, the whole matter was aired, and the following resolution was adopted:-

“That it is most desirable that a house should be obtained as soon as possible to be opened as a Christian home in the city. That this home should be under the management of Christian ladies, and for the reception of aged, infirm and indigent ladies, where they should be received, lodged and fed . . .”²

A large committee was appointed, and at a subsequent meeting held a few days later a sub-committee was entrusted with the task of drawing up details of the scheme. As a result it was resolved to appeal to the public for funds to establish “The Christian Home for Aged, Infirm and Indigent Ladies, and for Christian Workers.”³

¹ *The Ladies Christian Home Constitution para. 1*

² *The Story of the Ladies Christian Home (C. Blackshaw & Sons (Pty) Ltd 1976) p. 2; Minutes dd. 11th March 1876.*

³ *The Story of the Ladies Christian Home (supra) p. 2; Minutes dd. 28th March 1876.*

The appeal met with an encouraging response. Eventually on the 5th September 1876, the property known as “Buckingham House” situated on the corner of Vrede Street and Wandel Street was bought for £1000. Renovations were carried out, furnishings were provided, the first occupants moved in at the beginning of February, 1877, and the official opening of the Home took place on the 8th February, 1877. By October 1877, the number of residents had risen from six to eight.

The Home was primarily intended to provide security, comfort and caring for elderly ladies, but the needs of “Christian Workers” were not overlooked. For thirty-seven years Miss Hilder who carried out valuable work in the prisons and streets of Cape Town, resided in the Home. Occasionally temporary accommodation was found for lady missionaries passing through Cape Town or for ladies from the country for medical treatment. The Home was becoming ever more an oasis of love and caring in the growing city. ⁴

In 1893 alterations were done to the Home and repairs were carried out to the adjoining store, which had been bought in 1878. By 1894 the number of residents had increased from eight to fourteen.

In 1900 the Home was completely rebuilt incorporating the store. This increased the capacity of the Home to twenty-eight. The Home was re-opened on the 15th June, 1900.

The report of 1901 uses for the first time the present title “Ladies Christian Home” as an alternative to the original “Christian Home for Aged, Infirm and Indigent Ladies, and for Christian Workers”. ⁵

⁴ *The Story of the Ladies Christian Home (supra) p. 4*

⁵ *The Story of the Ladies Christian Home (supra) p. 6*

In 1913 extensions were carried out. New rooms were built over the dining room and the capacity was increased to thirty-four. In 1929 the adjoining property in Wandel Street was bought. This made possible the building of the Wandel Street wing. The work was carried out in two stages in 1931 and 1933. The first stage included five bedrooms and the second stage consisted of twelve bedrooms. The capacity was increased to forty-eight residents.

In 1938 the ground in Vrede Street adjoining the Home and extending to the corner of Barnet Street was bought. By 1942 the building had been reconstructed, extended and enlarged. The capacity was increased to fifty-six. In 1961 the Barnet Street wing was built. This consisted of eight new bedrooms, and brought the capacity of the Home to seventy.⁶

The final phase of the building operations occurred on the 10th February 1990 when the Buchanan Wing was opened. This was essentially a frail care wing and together with certain other alterations raised the occupancy of the Home to one hundred and twenty-two beds. The provision of a frail care wing was the ultimate expression of caring concern and the desire to improve the quality of life of the residents of the Home.

The Ladies Christian Home has grown and developed from modest beginnings to the Home it is today. It still fulfils its function of bringing peace, comfort and security to its residents, and assuring them of an improved quality of life.⁷

The historical development of the Home has been dealt with at some length for three main reasons. First, it gives the background to the investigation that will follow. Second, it manifests the caring concerns which have motivated the Home for almost a century and a quarter. Third, it evinces a drive, indeed, a compulsion to improve the quality of life of elderly ladies.

⁶ *The Story of the Ladies Christian Home (supra) p.10*

⁷ *The Story of the Ladies Christian Home (supra) p. 13*

1.2 Introduction

In leading in to the investigation, three matters need to be considered. The first relates to the constitutional position of the researcher. The second relates to the adequacy of the researcher to fulfil his constitutional function. The third relates to the findings of the researcher in qualifying himself properly to discharge his constitutional duties.

According to the Constitution of the Ladies Christian Home, “the management, government and general conduct of the Home shall vest in a Board of Trustees who shall exercise all powers necessary and requisite for carrying out the objects of the Home.”⁸

The objects of the Home, which incorporate its Mission Statement include the “provision for the sustenance, health and welfare of the residents of the Home”.⁹ The Mission Statement declares that the primary concern of the Home “is for ladies who are elderly, infirm and needy; to respect their rights, to accord them dignity, to attend to their welfare, and to ensure their freedom from danger, care or fear”.¹⁰

The researcher was appointed to the board of trustees in 1987 and was made Chairman of the board in 1994. He was accordingly charged with the duties that fell to the trustees in terms of the Constitution. He was faced with a problem:

While he had intimate knowledge of all the matters that regularly presented themselves on the agendas of the meetings of the board of trustees, he had little or no knowledge of the residents of the Home; their problems, their difficulties, their joys, their sorrows, their needs. He was ill-prepared to fulfil the duties incumbent upon him.

⁸ *The Ladies Christian Home Constitution para. 4.1*

⁹ *The Ladies Christian Home Constitution para. 3.2*

¹⁰ *The Ladies Christian Home Constitution para. 2*

He addressed the problem by seeking an appointment, on a voluntary basis, of a visitor to the residents. On being appointed he initiated a programme of visitation. This was no easy matter. There were no job descriptions, no manuals, no handbooks. Indeed, there were few books of any description to assist an untrained beginner. He, of necessity, had to devise and initiate a programme of visitation; develop and refine it over a period of two years by resorting, largely, to the 'trial and error' method.

What manifested itself from the developing programme was startling. This was not a case of creating a job and then looking for a reason or need. Problems presented themselves and answers had to be provided. Living was a problem, ageing was a problem, dying was a problem. Two thoughts arose. One was that in an age where counselling was being offered for all manner of traumatic experiences,¹¹ nobody in the Home was caring for the personal needs of the elderly. They were being left in their rooms to sort out their problems for themselves, or alternatively, to pretend that they did not exist. The other thought was to recognise the need or desire to speak to someone and to devise a means whereby these needs or desires could be met.

This is not a case of usurping the function of the psychologist or the geriatric psychiatrist or the expert in the field of gerontology. This is something different. This is 'visitation'. It involves the making of contact with a person on a regular and continuous basis; it involves the discernment of a state of health, a confusion of mind, the presence of a problem, and the need to talk about it to someone. It also involves the ability to deal with these matters in a simple, practical, authoritative and expedient manner.

1.3 Approach

The proposed investigation arose out of a programme of visitation, directed at a group of elderly ladies, residing at the Ladies Christian Home. This gives rise to

¹¹ See *Cape Times* of 9 November 1999 and *Cape Argus* of 5 November 1999 where grief counselling advice was being offered at University level for dejected rugby fans in the wake of the All Blacks' crushing defeat in the World Cup

four cardinal issues. One is the fact of growing old. In the absence of death, it cannot be avoided. It touches practically everyone, either directly, in the sense of they, themselves, growing old, or indirectly, in the sense of them being involved in the lives of others who are growing old. In one form or another it is difficult to avoid coming to terms with the nature and effect of the ageing process. More pertinently, those engaged in the care, concern and quality of life of the elderly must make themselves aware of the fact of growing old. Moreover, the fact of growing old cannot be viewed in isolation; there are problems attached to the process which have far-reaching consequences. The ageing process and the problems attendant thereupon must be understood. In order to understand them they must be investigated and researched. Accordingly, the fact of growing old and the problems attendant thereupon will be investigated and analysed both from the general point of view, and from the more specific point of view of providing a means to improve the quality of life of the institutionalised aged.

A second issue is that of “institutionalisation” and the problems related thereto. “Institutionalisation” covers a wide ambit and is far-reaching in its ramifications. It stands to be investigated from a number of points of view. The starting point is an examination of the institution itself in its various facets. No less important is an investigation into the process of institutionalisation. The nature, function and purpose of institutionalisation must be subjected to scrutiny, as must the effect of institutionalisation. “Institutionalisation” features as one of the most momentous experiences in the lifetime of an individual and cannot be regarded lightly in this inquiry. In the result, weighty consideration will be given to this aspect of the matter.

The third issue relates to the position of the resident. The nature and effect of the ageing process, the nature and effect of the process of institutionalisation, the problems that present themselves in the life and experience of an ageing person, and the need for counselling are all key issues which need to be investigated and researched if authoritative conclusions are to be reached and helpful recommendations are to be made. Accordingly, the approach to these, and related issues, such as the role played by the family in the initial and continuing institutionalisation process, cannot be viewed other than in the gravest light.

In the heart of this inquiry is the fourth issue, namely, the nature and scope of 'specialised visitation' and the benefits it can hold out for the elderly. The associated issue is that of the 'specialised visitor', that is, the requirements, characteristics and qualifications of a 'specialised visitor' and the specialised nature of the role such a visitor is required to fulfil. The title of the dissertation is indicative of the importance of these aspects of the matter. The approach accordingly will be to determine the precise nature of 'specialised visitation', whether there is a need for such a form of visitation and if so, what are the facts and circumstances giving rise to such a need, and whether this form of visitation holds out any benefits or advantages to the resident. In other words, can 'specialised visitation' improve the quality of life of the aged. If it is found that 'specialised visitation' does hold out benefits and advantages to the aged, and does improve their quality of life, the next obvious question to be examined is: what personal characteristics and qualifications must a 'specialised visitor' possess? These are matters of singular importance and lend themselves to detailed investigation.

1.4 Conclusion

An historical background has been given against which the investigation and research will proceed. An introduction has been provided setting out the facts and circumstances which initiated the investigation, the keynote of which is the welfare and quality of life of the institutionalised aged and how this can be improved and enhanced. The approach to the problem and the investigation has been sketched setting out the main points of the investigation. Obviously, a more detailed and probing exercise will follow.

Attention is now directed at the second subject to be discussed, albeit on a preliminary and introductory basis, namely, "The nature, scope and purpose of the investigation; the method adopted and the limitations".

Chapter 2. THE NATURE, SCOPE AND PURPOSE OF THE INVESTIGATION : THE METHOD ADOPTED AND THE LIMITATIONS

2.1 The Nature of the Investigation

In determining the essential quality or character of the investigation, a number of factors need to be considered. The first of these considerations is that the investigation arose out of a programme of visitation as it existed in its initial stages. There were sporadic visits to residents who were unknown to the researcher and to whom the researcher was unknown; he was no more than a stranger who introduced himself as the Chairman of the board of trustees. At the same time they were visits confined to those who resided in the 'front part of the Home'. By way of explanation, it may be said that those who were resident in the 'front part of the Home' were those who were more mobile, more physically able, and more intellectually capable than those who resided in the 'back part of the Home', more commonly known as the Frail Care Wing. To a lesser or greater extent, and in most instances, they were better able to converse and convey their emotions than those in the Frail Care Wing. On the one hand, therefore, the visits were occasional, unfamiliar and limited; on the other hand, they were confined to people who were sound of mind and reasonably articulate in expression.

Even at this early stage, and in what must be admitted to be limited circumstances, certain tentative observations were made and provisional findings, recorded. Manifestly, there was a desire to communicate, or, at least, to be recognised. The situation could be rationalised on the basis that the Chairman of the Home was visiting a resident, or on the basis of a limited contact with the management or administration in the face of a visit by someone in authority who had the time and interest to visit a resident.

Rationalised or not, residents were ready and able to talk, sometimes on confidential matters. Apart from these tentative observations and provisional findings, no conclusions were drawn. Indeed, the matter was further rationalised on the basis, in some cases, of a lack of ordinary or regular visitation. Some of the residents received no visitors at all. In any event, it was determined that there were certain deficiencies in ordinary or regular visitation, in the sense that these were sporadic and disjointed, and sometimes filled with tension. They were not conducive to discussion on a deep and meaningful level.

With the passage of time and the introduction of a more systematised programme of visitation certain matters became clearer. The effect of regular, continuous visitation is to provide an opportunity to make physical and mental observations. It is not suggested that such observations are scientific or even an accurate revelation of a state of health or a mental condition. It is however an indication of a particular state of affairs and it does provide a basis for intelligent and relevant discussion. Regular and continuous visitation gives rise to a desire to talk; it opens the way to unconditional acceptance and a building up of confidence. Over and above all things else it leads to a disclosure of problems and an expression of needs.

Continuous and regular visitation exposes the problem of having to provide a means to meet a need. It may be argued that this need must be met by the management and the administration, and to a certain extent they do fulfil a vital role in this regard. They are however limited by time constraints and the demands of administration. To deal with personal problems is time-consuming; it requires a measure of expertise and demands sensitivity and patience.

The question arose, and arises still : is there a need for 'specialised visitation'? This is at the heart of the investigation. If there is a need for 'specialised visitation' the inquiry broadens to determine the facts and circumstances giving rise to such a need. The nature of the investigation embraces an inquiry as to what the benefits and advantages of 'specialised visitation' are, for without some form of benefit and advantage it can hardly be argued that it is a means of improving the quality of life of the elderly.

As to what constitutes 'specialised visitation' and a 'specialised visitor' fall within the ambit of the investigation; indeed, it is a cardinal aspect of the investigation. Moreover, the role of the institution and the process of institutionalisation cannot escape analysis. What duties rest upon institutions in relation to the private and personal needs of residents? This is a valid question and stands to be answered. Likewise, the nature and effect of institutionalisation. This forms an important part of the investigation.

Reduced to a single proposition, the nature of the investigation is to determine the value of 'specialised visitation' as a means of improving the quality of life of the elderly.

2.2 The Scope of the Investigation

In setting out the extent or range of the investigation, it is important to observe that first and foremost, it is people who are being dealt with; people who are aged and institutionalised; people who, to a very large degree, are indigent; people with feelings; people who are harbouring physical, mental, emotional and spiritual problems. The people who form the subject matter of this dissertation are people who, more often than not, have outlived their contemporaries, their friends, and even their families.

Some are not visited at all; some are visited only occasionally. Some want to talk about deep and meaningful matters but have nobody with whom to talk. The investigation examines people, not in isolation, but engaged in the process of living, albeit restricted, confined and limited. These are the people who are embraced in the ambit of the investigation.

The institution, in its various facets, falls within the scope of the investigation, as does the process of institutionalisation. The person cannot be divorced from the institution, nor can it be divorced from the process. For some it is a simple change-over from one situation or state of affairs to another; for others it is a traumatic transfer, the effect whereof is lasting and painful wounding and distress.

The person becomes the resident and in that role she is carefully analysed and assessed. A multitude of considerations present themselves, all of which have bearing on the ultimate findings: the pre-institutionalisation position, the nature and effect of the process of institutionalisation and the reasons therefor, the nature and effect of the ageing process, the physical, mental and material requirements of the resident, and the need for counselling. These are all matters that invite research and fall within the ambit of the investigation.

Families often play a dominant role not only in the initiation of the process of institutionalisation but thereafter. These aspects are important from differing points of view. It does happen that institutionalisation is motivated by the family, and in their own interests, not in the interest of the resident. Once institutionalised, the resident is, to all intents and purposes, abandoned, and the family takes no further interest. The resident is left to fend for herself and find answers to her own problems. A second situation manifests itself where the family continues to take an interest in the resident but the relationship is characterised by confrontation, conflict and unpleasantness. The relationship is such that it can never lend itself to meaningful dialogue, and certainly not to a participation in personal problems and emotional stress on the part of the resident. Yet a third situation arises where visitation is frequent and meaningful, and the resident's problems are resolved within the family circle. A transfer of responsibility can occur where the resident has no family or friends. This is unfortunate. Where, however, there is a family, the importance of the role that family can play, especially in cordial circumstances, cannot be overemphasised.

Whether the family situation is good or bad, it must be investigated, as it has direct bearing on the mind and emotional state of the resident, and falls within the scope of the investigation.

It goes without saying that visitation, in its normal or regular pattern, or in a 'specialised' pattern, is at the heart of the investigation. The normal or regular pattern is readily accepted, understood and appreciated. But what of 'specialised visitation'? Is there a need for such an activity? If so, what are the facts and circumstances giving rise thereto, and what are the benefits and advantages arising therefrom?

This all presupposes an understanding of what ‘specialised visitation’ is all about. Without an investigation there cannot be an understanding.

Moreover, an investigation cannot be complete without some indication of the reaction thereto on the part of the resident. Is she opposed to this ‘regular and continuous’ invasion, or is she receptive and genuinely cordial? These are matters that need to be analysed and assessed before conclusions can be reached and recommendations advanced.

Hitherto, the normal or regular pattern of visitation has been the accepted mode of conduct. Why is there now a need to change a longstanding practice? Perhaps the answer lies in the fact that people are becoming more aware of the emotional needs of the aged, and more committed to ministering to these needs in a general quest to improve the quality of life of the elderly. Whatever may be the answer, the fact remains that the problem requires investigation, and if needs be, appropriate action.

One of the objects of the Home is “to provide means whereby spiritual guidance, teaching and encouragement may be given to the residents of the Home; all such to be consistent with ... and in keeping with Evangelical, Protestant and non-sectarian principles,” and “to provide as far as is reasonably possible for the presentation of the gospel of salvation through faith in the Lord Jesus Christ”.¹ The question that arises is whether the objective of any visitation programme ought not to be the presentation of the Christian Gospel. In other words, is the programme essentially religious in character, or can it be of a secular nature? This question has not escaped the attention of the researcher, and falls within the scope of the investigation.

If then the meaning and purpose of ‘specialised visitation’ falls within the scope of the investigation, it follows, as a matter of logic, that the requirements, characteristics and qualifications of the ‘specialised visitor’ must similarly fall

¹ *The Ladies Christian Home Constitution para. 3*

within its scope. More than that. The investigation must analyse and assess the 'specialised nature' of the role he is required to play in all its many facets; it must look into aspects of communication; indeed, it must probe the function of the visitor in the face of a resident's death.

The scope of the investigation is far-reaching and wide; after eighteen months of intense endeavour the matter remains unresolved, and only with painstaking and careful research can valid conclusions be reached and recommendations advanced.

2.3 The Purpose of the Investigation

Uppermost in the mind must always be the question; what is the aim, what is the intention of the investigation; at what end is it being directed?

Simply but generally stated the primary purpose of the investigation is to determine a means or a variety of means whereby the quality of life of the aged can be improved. But there are other and associated purposes.

Among these purposes is an investigation into the nature and effect of the ageing process and the problems attendant thereupon. Another purpose of the investigation is to determine the nature and effect of the process of institutionalisation and the problems attendant thereupon. A third purpose is to determine ways and means of dealing adequately with the problems associated with the ageing process. A further purpose of the investigation is to examine the nature and effect of 'specialised visitation' and to determine whether there is a need among the elderly for such a programme of visitation. Concomitant with these purposes is the sixth associated purpose, namely, that of investigating the facts and circumstances giving rise to a need for 'specialised visitation', if any; and the seventh, which involves an assessment of the advantages and benefits (if any) of a programme of 'specialised visitation' to the elderly. A further concomitant, which embraces a number of facets, is an inquiry into the character, qualities and role of the 'specialised visitor'.

Accepting the validity of the various enumerated purposes of the inquiry, the question remains ; what is the end to which these various purposes are directed. The answer to this question is two-fold : (a) to arrive at valid conclusions relating to the quality of life of the institutionalised aged; and (b) to make recommendations, the ultimate purpose of which is an improved or enhanced quality of life of the elderly.

It may be helpful, at this early stage of the investigation, to highlight the principal aspects thereof, in greater detail, and to indicate the context wherein a particular aspect will be dealt with.

Firstly, and of singular significance, is the observation that ageing is a process. It begins with birth and ends with death. Its nature can be monitored and observed; its effects can detrimentally disturb the quality of life of the ageing person. Section D deals with the resident and in Chapter 8 the nature and effect of the ageing process is considered.

Secondly, and of no less importance, is the process of institutionalisation, which is not only viewed as a means of improving the quality of life of the elderly, but also as a matter of extraordinary change in the life of the aged person. It is a process which requires that sympathetic and sensitive assistance to be given to the aged person adapting to an institutionalised situation. This, too, is dealt with in Section D but in Chapters 9, 10, 11 and 12 where attention is given to the pre-institutionalisation position, the nature and effect of the process of institutionalisation, the reasons and causes of the process, and the need for counselling.

Thirdly, attention is directed at the manner in which the ageing process must be dealt with. To ignore it or to neglect it can give rise to grave consequences. In this regard, it is the family that must play a pivotal role in a number of contexts. Section E deals with the family and in Chapter 13 consideration is given to the role of the family before, during and after the institutionalisation process, while in Chapter 14 the institutionalisation process is examined from a more personal perspective in relation to the aged person within the context of the institution, such as meeting the physical, mental and emotional needs of the elderly person, and providing informal

counselling. In dealing with the ageing process, there is an interrelationship of the family with the resident and the institution, and this is considered in Chapter 15.

Fourthly, the matter of visitation receives no small notice. Section F is devoted to the subject of visitation. In Chapter 16 attention is directed at the meaning and purpose of visitation; Chapter 17 at the need for visitation, and in Chapter 18 the normal or regular pattern of visitation is analysed and assessed. At the heart of the subject is the matter of specialised visitation and the specialised pattern of visitation is dealt with, in some detail, in Chapter 19.

Fifthly, an argument is advanced in support of the need for a specialised pattern of visitation. A distinction is drawn between the need for visitation from a general point of view, and the need for visitation from a 'specialised' point of view. A disturbing tendency towards entrenchment and isolation on the part of the institutionalised aged presents a problem. In Chapter 17, the researcher advances the suggestion that the answer to this problem lies in 'specialised visitation'. The researcher indicates that the normal or regular pattern of visitation fails in its objective to improve the quality of life of the aged. He argues that the alternative lies in a specialised pattern of visitation.

Sixthly, and still in Section F, but in Chapter 21, the facts and circumstances giving rise to the need for a programme of specialised visitation are analysed and assessed. The objective of the researcher, in this analysis and assessment, is to determine the situations which present themselves in the experience of an elderly person that advance the argument that specialised visitation enhances and improves the quality of life of such elderly person. He probes a number of the effects of the ageing process, such as advanced age, infirmity, ill-health, adversity, lack of self-esteem, fear and the need for encouragement and concludes that facts and circumstances are present in the life and experience of an aged person that support the introduction of a programme of specialised visitation.

Seventhly, in Chapter 20 of Section F, the researcher seeks to answer the question as to whether specialised visitation holds out any benefits and advantages to the institutionalised resident. He accepts the challenge that the care of the aged must be

purposefully linked to an improved quality of life of the elderly, and that specialised visitation, as an aspect of such care, must hold out benefits and advantages which redound to an improved quality of life of the aged. He observes that a pattern of specialised visitation is characterized by continuity, regularity and frequency; it involves personal contact; it manifests compassionate concern, interest, care, and the offer of support; its typical and distinctive features include stability, certainty and security. He has no doubt in coming to the conclusion that a programme of specialised visitation does hold out benefits and advantages and that the introduction of such a programme is justified.

Lastly, the researcher, having dealt, extensively, in Section F, with the subject of visitation in eight chapters, turns his attention in Section G to an analysis of the visitor. He is at pains, in Chapter 24, to set out the requirements, characteristics and qualities of the specialised visitor. These vary from standing in the community to humility, sensitivity and patience. He must be sympathetically disposed towards the aged residents; he must be motivated in the sense of being spurred, stimulated and prompted to the ultimate end of providing an enhanced and improved quality of life for the elderly; and he must possess the quality of perception. In Chapter 25 the researcher turns his attention to the specialised role of the visitor wherein he highlights, among many attributes, the need to be an encourager, a strengthener, a comforter and an uplifter of the emotionally disturbed. He is required to be a bearer of hope, a bringer of peace and an instiller of faith. The researcher concedes that the demands of specialisation are exacting but not beyond those who are called to the task.

Accepting the fact that the ageing process does give rise to unfortunate consequences, the question arises as to what can be done, if anything, to enhance and improve the quality of life of the elderly.

2.4 The Method adopted in the Investigation

Here, a single answer is being sought to a two-fold question: hitherto, in what way or according to what plan has the investigation been conducted; likewise, for the future of the investigation, in what way or according to what plan will the investigation be conducted?

The starting point was (and is) the recognition of a problem and the attendant desire to resolve the problem. The problem may be identified thus : people were growing older and in the process were becoming more isolated. At the same time they remained personalities with problems, difficulties, feelings, needs. How were these matters to be met, and who was to attend thereto?

With the passage of time coupled with a programme of regular and continuous acts of visitation, the assumption was made that the problems could be resolved by a process of specialised visitation.

This led to an intensification of the programme of visitation during which observations were made and experiments with human conduct were performed. The resultant data was assessed and interpreted and a preliminary conclusion was reached, namely, that the quality of life of the institutionalised aged could be improved and enhanced by the development and introduction of a programme of 'specialised visitation'.

Before proceeding further with this matter, it is opportune to reflect on how the research was done, and why it was done in a particular way.

The first step was to systematise the visitation programme into a process whereby the name and room number were recorded in a monthly schedule and, whereupon was noted the visits to each resident. As part of the system, it was important to know something about the general condition of the resident. To be able to address a person by name is important, but so is a knowledge of that person's general condition. Is she suffering from some physical malady or some form of senile dementia? Is there some other problem? For instance, has she a phobia about men? In certain cases, the cause is advanced by avoiding visitation, at least, until the stumbling blocks are removed. At the commencement of the programme, the researcher was advised not to visit two residents because of certain phobias. By wise and careful handling of the problems, the difficulties were overcome,

confidences were built-up, and warm relationships resulted. The physical disability or senile dementia might seriously affect a visit, and to disregard them, could result in distressing consequences. To expect a resident, who is seriously affected by some of other form of dementia, to engage in intelligent and constructive conversation, is to expect too much, and will not assist in the visitation programme. The starting point, therefore, is to know the name of the resident, to know her room or ward number, to know something about her general condition, and to record the act of visitation.

Allied to the first step, and closely akin to it, is a knowledge of the resident's background. It is advisable that this be objectively ascertained, as the word of the resident is not always accurate or sustainable. The General Manager, the Sister-in-Charge, and the Bursar, in one way or another are intimately involved in the admission process, and gain valuable information relating to the resident and her background. Another source of information relating to the background of the resident, from the point of view of the interest shown in the resident by her family and friends, and to which reference will be made shortly, is the receptionist and her visitation record. The researcher, in the course of developing the visitation system, kept in regular and close contact with these sources to ascertain whether he knew and understood the resident sufficiently well to engage in regular and meaningful contact with her; whether he could accept and rely upon the veracity of what was being conveyed to him; and whether it behoved him to take notice of what he was being told. Of course, the researcher had a mind of his own, and was not entirely dependent on the information being furnished to him. Armed with his own knowledge, his own observations, his knowledge of the resident's condition and background, he had to exercise his own judgement in determining the course to be taken in any particular situation. Moreover, to a limited, but nonetheless relevant, extent, he came into contact with family and friends, who, to a lesser or greater extent, assisted him in understanding and appreciating the background of the resident.

The third step manifested itself in making contact with the residents. This was not mere contact, as contact which lacked continuity, regularity and frequency was disruptive, confusing and not amenable to giving rise to confident expectation, assurance and certainty. What is at the heart of a programme of visitation is the building-up of confidences, of formulating reliable relationships, and, of being able to talk with visitor in a frank, open and sincere manner. This does not come about overnight nor does it happen without effort. It requires persistence, tenacity and resolute continuance. Accordingly, residents had to be visited continually, regularly and frequently. It must be remembered that for most residents, the day is long, and the memory short. As the years increase, so activity, agility and alertness decreases. Likewise, hope, imagination and expectation become limited. Indeed, in the experience of the researcher, the one event to which there is a longing and an anticipation, is the call of the visitor. Moreover, lapses which may be more apparent than real, give rise to desperation, despondency and disturbance. So much so, that should a public holiday, or absence from the Home, intervene, messages are sent to find out "what has happened to Dr Prest?" It is not necessarily the duration of the visit that is important, but the frequency of the contact. The visitor becomes a chattel, the possession of which gives rise to security, confidence and stability. This state of mind, or feeling of the emotions, is upset when there are lapses, discontinuations or infrequencies in the pattern of contact.

Mere contact, as continuous, regular, and frequent as it may be, does not suffice. It must be contact which gives rise to meaningful communication. This implies a transfer of information, facts, wishes or emotions from a source to a receiver. It also implies two sources, and two receivers, the visitor being a source and a receiver, and the resident being a source and a receiver. It also embraces a number of ideas. Springing readily to mind is the idea of communicating meaningfully by talking. At first, this falls largely to the domain of the visitor who must initiate, perpetuate and guide conversations. At the same time he must acquire the skills to elicit responses from the resident. It must always be borne in mind that, by the very nature of the resident's situation, the prospect of lively and stimulating conversation from the

resident, is remote. He must display a probing interest and an enquiring mind, without seeming to be inquisitive or prying into the affairs of the resident. At times, the conversation is limited to a few brief exchanges. As limited as these exchanges may be, they are, none the less, significant in the overall scheme of things, and meaningful. With the passage of time, and tenacious but sympathetic persistence, confidences are built-up, relationships are formed, and a readiness to pierce the veil of silence manifests itself. It is then that the efforts of the visitor are rewarded, and it is then, that the visitor must acknowledge that there is a further element to meaningful communication. It lies in a readiness to listen sympathetically and patiently. But what of the situations where an exchange of conversation is impossible or limited by reason of the resident's condition? The researcher has had to learn the art and worth of the sense of touch. Where words fail, tactility presents itself as a powerful tool in the art of meaningful communication. The secret lies not in the touch, however gentle and loving it may be; the secret lies in the response, warm, tender and appreciative.

Just as tactility manifests itself as a useful tool to those who cannot or will not express themselves orally, so other tools present themselves as an aid to those who can express themselves orally but who are limited in their topics of conversation.

There are, in the Home, residents who are avid readers and who patronise the weekly library service. A library book, or other literary work of interest, can give rise to meaningful communication between the resident and the visitor. It may require time and attention, even outside expertise, but if it gives rise to some form of exchange, in the overall scheme of things, then the effort is not without avail. Likewise, the newspapers. The Home provides a certain number of daily editions for the resident. The selection of an item or various items of interest, albeit something as mundane as the weather, local or overseas, can give rise to topics of discussion and conversation. The items themselves are not important. Their importance lies in consequent exchanges, the building-up of confidences, and the forming of relationships. Many of the residents have private television sets, and all have access to communal sets. A television programme can give rise to conversation but what is required is diligent preparation and not indifference or

haphazard uncertainties. Photographs have a special appeal to the elderly, and a photograph album can give rise to interest, curiosity and engagement. It is not an end in itself. It is means to an end, and skillfully and pointedly used, can be a useful tool in the ultimate design.

Communication is one thing. What arises out of the communication is another. It can lend itself to further uses. It can be a means of making observations in regard to the general condition of the resident. It is not suggested that the art of conversation be employed for ulterior motives. On the contrary, what is suggested is that every available means be employed for the ultimate benefit of the resident. Accordingly, the contact and the communication consequent thereupon must be usefully employed to detect the possibility of any physical malady or mental affliction. Perhaps, of even greater significance, it can be used to ascertain any emotional disturbance on the part of the resident. These incidences occur, and they occur with regularity. It may be that they are not immediately picked up by the nursing staff or General Manager. In the meantime, however, the resident suffers, and she suffers in silence. Where such observations are made by the visitor, they are directed to the appropriate channels, with the result that effective healing or appropriate counselling can be administered to the resident.

But observation need not be limited to the general condition of the resident. Observations can lead to the detection of problems and difficulties which are present in the minds and hearts of the resident. This is not an unusual occurrence and it gives rise to no small degree of disturbance and distress. What are the pointers that reveal, to the observant onlooker, that something is amiss and that it may be giving rise to trauma and upset. As unscientific as it may sound, much is revealed by a resident in the countenance she displays.

The expression upon a resident's face, her appearance or attitude may be eloquent and convincing testimony that all is not well. In like manner, her body language or unconscious gestures may be such as to depict a very unhappy person. The observant visitor, in his conversation with the resident, and drawing on his ability to share, understand and feel the resident's feelings may well reach the conclusion that something is radically wrong. He may try to detect the nature of the problem or

difficulty, or he may try to understand what is wrong. One thing is certain. To allow the condition to persist is to disregard a painful message emanating from a disturbed person. The visitor himself may not be able to handle the situation successfully but he is not without resources. The probabilities favour the visitor referring the matter to the General Manager for appropriate action. The agency is not important. The end result is. As a result of observations made by the visitor during communication with a resident, a distressing situation is alleviated and an enhanced quality of life is achieved for the resident.

It may seem a small, even insignificant, means of reflecting how the research was done but it has merit and it makes a contribution to the solution of the research problem. It relates to the celebration of the birthday of each resident. On the anniversary of the birthday, each resident is wished, given a card from the management, and presented with a small gift. The scheme is administered by the specialised visitor. It is he who conveys the wishes, delivers the card and presents the gift. It is he who fetes the resident, makes the occasion special, and causes her to feel good. It is he who honours the day, makes the contact, engages in meaningful communication, and observes the resident. Where the response is a coy, unbelieving smile of acknowledgement, he knows that he has achieved something out of the ordinary and something very special. What is unspoken tells him that he is being applauded for remembering, for singling her out, and for levelling at her expressions of praise. This is not always the case. The response is sometimes a confused and perplexed bewilderment, from which he observes that the ravages of dementia are such as to render the anniversary of a birthday meaningless. The event is, none the less, celebrated in the best way possible.

Bingo is a game in which each player has a card with a set of numbers on it, and may cover a number if it is called out at random by the bingo-caller. The winner is the first player with a card on which all or a certain sequence of the numbers have been called. Prizes are awarded according to various degrees of achievement. It is very popular among the residents and it is run by the specialised visitor. The

residents see it as pleasurable entertainment. The administration see it as a form of therapy. The fact remains that it is a point of contact between the residents and the specialised visitor. It is also a mode of meaningful communication and social interaction. The occasions are happy, they enhance the quality of life of the residents, and they contribute to the solution of the research problem.

The researcher acts as specialised visitor and occupies an esteemed position; he is respected and thought of highly. He exercises a specialised role, being the Chairman of the Board of Trustees of the Ladies Christian Home for a number of years, as well as acting as General Manager of the Home during periods when the appointee has been away on holiday. He is adept at conducting services of worship in the Home, and from time to time, leads memorial services with equanimity and aplomb. In addition, he fulfills a specialised function. While not acting as the legal advisor to the Home, or to any of the residents, he has a vast legal knowledge, he is able to offer a measure of assistance to residents in regard to Wills and Estates, and often helps them with banking problems. He has a wide knowledge of relevant issues and is able to discuss with residents matters relating to art, politics, world affairs and the weather. He is a churchman of standing and regularly shares with residents in devotions and prayer. His company and presence is sought-after and he enjoys a fine rapport with the ladies. He has a limited knowledge of a variety of health conditions and readily identifies with the elderly on conditions such as arthritis, colds and flu. He occupies a centrally-situated office of fine proportions, nicely appointed, largely at his own expense, at which he is readily available by appointment and informally. In his voluntary occupation, he exercises an independent, mediatorial role. Technically, he has no part of the management of the Home but is answerable to the Board of Trustees. He is not averse to reacting to comments made by the residents but he recognises the scope of his activities as a voluntary visitor and he is careful not to interfere with the management of the Home. Where he feels his interventions would be helpful in such management, he resorts to a modest, measured and wise approach, to avoid conflict and

confrontation. Against this background, he readily responds to requests of residents, expeditiously reacting to cases of crisis. He is at pains to identify with the resident's condition and to acquaint himself with the background to her problem. These comments are offered as an exemplification of the role and function of the specialised visitor and as such, a method to be employed in the solution of the research problem.

In reflecting upon the methods adopted in the research undertaken in this matter one last aspect needs to be considered, namely, the information imparted by the Receptionist and the contents of the Visitors' Book. The Receptionist, or her substitute, admits all visitors to the Home. The visitors are required to sign the Visitors' Book on entering and leaving the premises. They are also required to indicate the person whom they are visiting. Discussions with the Receptionist and perusals of the Visitors' Book make good the period when the specialist visitor is not on duty. They go a far way in confirming the argument advanced, namely, that the ordinary pattern of visitation is far from satisfactory and there is a need for specialised visitation, not only to add to a haphazard visitational programme but to be available to meet the resident at her point of need and to administer caring compassion. For instance, over a period of 3 months, when there were approximately 100 residents in the Home, 6 received visitors every day, 38, once a week, 34, one a month, and 18 had to wait for 2 months or more for a visit. Some received visitors on rare occasions, some, none at all.

The methodology employed in the research has been examined under a number of main points, as well as under a number of subsidiary points relating in particular to the role and function of the specialised visitor as an aspect of research employed in the solution of the problem.

The reasons for adopting is particular methodology are now addressed. They are four in number.

- First and foremost, it must be accepted and understood that this work was not conceived initially as an academic exercise. It was initiated, implemented and developed as a visitation programme, aimed at enhancing the quality of life of the elderly. The researcher, in his capacity of Chairman of the Board of Trustees of the Ladies Christian Home, was uninformed and unaware of the workings of the Home. More particularly, he was lacking in knowledge regarding the identity, condition and circumstances of the residents. It was his intention to remedy this ignorance by way of a programme of visitation. It was during the implementation of this programme that certain facts emerged, observations were made, and conclusions were reached that inspired him to enlarge his vision and to embark upon a study that might be more helpful. An assessment of the methodology employed will indicate a strong practical bent. This is because visitation is essentially a practical matter.
- Secondly, it must be accepted and understood that the visitation programme was being directed at people, with the view to enhancing their quality of life. At first, there was no problem to be solved, no theory to be proved, no experimentation to be done, no data to be interpreted, no conclusions to be drawn. Indeed, there were no preconceived ideas at all. There were just elderly people to be visited. People, not scientific exhibits, or human guinea pigs. Moreover, there were no hidden agendas or ulterior motives. People were being visited because they were people, and not for the purpose of achieving an academic qualification. The situation was one of good faith, of mutual trust, of honesty and sincerity. With hindsight, no other course could have been adopted, as it may well have detrimentally affected the desired result.

The methodology may have been simplistic, naïve and excessively practical but it had a particular end in mind, and that end was achieved. Hence the adoption of the method of research.

- Thirdly, and armed with hindsight, the question arises as to what other methodology could have been employed. In considering this question, three things must be borne in mind. Firstly, the average age of the ladies is 86½ years. Secondly, of the 110 residents, approximately 48% are, in one way or another, affected by some form of senile dementia. Thirdly, to subscribe to a document (assuming its contents are understood) is, for many, a complicated task. For instance, the prospect of being able to deal with a questionnaire, however simply formulated, or other form of quantitative investigation, is remote indeed. Regard being had to the factors mentioned it becomes apparent that there is considerable merit in the methodology employed.
- Fourthly, the matter of comparative study and investigation, must be considered. Indeed, it has been suggested to the researcher, at least in respect of doctoral attainment, that comparative study and investigation, on a wide basis, that is to say, a number of other old age homes, would be essential. This caused the researcher to consider a degree on a lower level, it being of considerable importance to him to pursue his interest in and commitment to, the Ladies Christian Home. It is conceded that the methodology employed does not admit of comparative study and investigation. However, it is not conceded, in the light of the achievements attained, that the methodology employed is thereby rendered suspect or limited.

This conclusion mentioned above led to a further problem. The development and introduction of a programme of 'specialised visitation' necessarily involved the introduction, equipping and training of 'specialised visitors'. Problems gave rise to problems. What must the 'specialised visitor' possess by way of personal characteristics and qualifications? The answer to the various problems lay in an analysis and appreciation of the nature and scope of 'specialised visitation'.

The sphere of operation had to be analysed and defined; the nature and demands of the various needs had to be observed and noted; what was the nature of the skills required by the 'specialised visitor'; what standard must be applied to measure the ability of the 'specialised visitor' to exercise these skills and deal with the needs.

Preliminary and provisional conclusions were reached, and in the light of these conclusions certain preliminary and provisional recommendations were formulated and advanced. These conclusions stand to be varied and amended in the light of further findings, as do the preliminary and provisional recommendations that have been formulated and advanced.

2.5 Limitations attaching to the Investigation

The limitations attaching to the investigation constitute a hindrance or handicap or restriction to the validity of the conclusions reached and the recommendations advanced.

Limitations are acknowledged. Firstly, the Home is for ladies only and no admission of men is envisaged for the future. This in itself is not necessarily a limitation. The 'specialised visitor', however, is a male. Accordingly, it was felt but not definitely experienced, that there were restrictions on the matters discussed. Moreover, occasions presented themselves when it was neither convenient nor appropriate to visit the resident. That a female visitor should visit a lady is obviously the desirable situation, and, it is assumed, such a situation might lead to more frank and open conversation.

Secondly, while there are residents of colour in the Home, they are small of number and the racial composition of the Home must be said to be largely white. Accordingly, the validity of the findings may well be suspect, in that they apply to one racial group only.

Thirdly, the investigation relates to the Ladies Christian Home only; there is no comparable study, either of a local or international nature. In so far as a reason is called-for, this lies in the essential nature of 'specialised visitor'. It has been emphasised that its key component is 'regularity and continuity' which does not easily lend itself to visits to other homes; nor is there readily available publications from which comparisons can be drawn.

Fourthly, the 'specialised visitation' programme was carried out on week-days, and not over week-ends. The point is made (not necessarily relevant) that 'ordinary or regular' visitation often occurs over week-ends. It is doubted, however that this factor does constitute a limitation. Nonetheless, the matter is raised.

The researcher makes bold to suggest that the limitations are not of such a nature as to affect the validity of the conclusions reached or the recommendations advanced. The most cogent limitation, it could be argued, is the one that embraces racial connotations. The counter-argument, it is suggested, is that the key to the validity of the conclusions reached is 'institutionalisation'. In other words, once 'institutionalisation' constitutes a factor in the investigation, the racial composition of the institution is irrelevant.

2.6 CONCLUSION

The ambit of this chapter has been wide but it has encompassed important and relevant considerations, and considerations, without which, the investigation would be imperfect and incomplete.

Attention is now directed to Section B which refers a case study conducted at the Ladies Christian Home during the period 1998 to 2001. This case study is the basis of the investigation. The observations that were made during the case study are recorded in six sections each dealing with a particular aspect of the investigation, and each introduced appropriately. Each section is divided into a number of chapters under descriptive headings. In these chapters, the relevant findings made in regard to the particular subject matter, are set out. The case study deals, at the outset, with the social structure of the Ladies Christian Home in Chapter 3, and its social function in Chapter 4.

SECTION B. CASE STUDY**Chapter 3. THE INSTITUTION : ITS SOCIAL STRUCTURE****3.1 Introduction**

In the absence of definition, or at least, comprehensive explanation, terminology can be confusing, even misleading. What is meant by the social structure of the Ladies Christian Home? The Home is a social institution or group of people that performs a specific function within society. As a social institution it has its own social structure and standards of acceptable behaviour. The social structure is an organised association concerned with people in their relations to each other, especially as it determines the peculiar nature or character of the association. Accordingly, the Ladies Christian Home is an organised association of people acting in relationship one with the other and thus giving to the Home its particular character.

It is not suggested that this definition, or description, is either comprehensive or all-embracing. Indeed, the concept of 'social structure' does not admit of easy definition.¹ Nonetheless, the idea of 'social structure' is at the very heart of sociology as a scientific enterprise.² Accordingly, an understanding and appreciation of the concept of social structure is of singular importance. It may be helpful to this understanding and appreciation if reference is made to certain basic concepts which characterise the social structure of a particular social institution. As will presently be seen, the Ladies Christian Home is a 'formal organisation'³ in the sense that it is a social entity expressly formed, planned and run with defined objectives in mind, formally (and informally) stated rules and regulations, and a system of specifically defined roles, each with clearly designated rights and duties.

¹ Neil J. Smelser: *Handbook of Sociology* : Sage Publications, Inc. (1988) p. 23; p. 105

² Neil J. Smelser : (*supra* at fn 1) p. 103

³ Neil J. Smelser : (*supra* at fn 1) p. 140; *Societas 7: Sociologiese Begrippe 1-50* : Dian Joubert : Universiteit van Stellenbosch p. 30

Indeed, its validity and legitimacy arises out of a formally adopted and binding Constitution. Secondly, the Ladies Christian Home is a 'collectivity' or a group of individuals who share a distinguishing characteristic in common and are recognised generally as a group that share a common position in the structure of society.⁴ Thirdly, the social structure of the Ladies Christian Home reflects a consensus on values, norms and role-expectations on the part of the individuals which, together, comprise the whole.⁵ Fourthly, the social structure of the Ladies Christian Home is maintained by the activities and interactions of the individual human beings and of the organised groups into which they are united.⁶

It is against this background that it is proposed to examine the social structure of the Ladies Christian Home. In the first place aspects of the constitutional structure will be referred to. Secondly, the various facets of the permanently appointed structure will be noted. Thirdly, the structure which is appointed on a part-time basis will be set out. Fourthly, the structure appointed on an outsourced basis will be observed. Fifthly, reference will be made to an aspect of the structure which is not appointed formally. Lastly, attention will be directed at the largest component of the social structure of the Ladies Christian Home, namely, the residents of the Home.

3.2 Constitutional Structure

In two respects the Constitution determines the nature and function of the parts that comprise the management of the Home. The Board of Trustees is the governing body and its composition⁷ and authority⁸ are set out in the Constitution. The appointment and duties of a General Manager is also a Constitutional matter.⁹ There are a number of significant features related to the appointment of the General Manager and these will be dealt with presently.¹⁰

⁴ Neil J. Smelser : (*supra* at fn 1) p. 141; *Societas 7* (*supra* at fn 3) p. 37

⁵ Neil J. Smelser : (*supra* at fn 1) p. 49, 50 and 124; *Societas 7* (*supra* at fn 3) p. 45, 51 and 73

⁶ Neil J. Smelser : (*supra* at fn 1) p. 49

⁷ *The Ladies Christian Home Constitution* para. 4.1.2

⁸ *The Ladies Christian Home Constitution* para. 4.1.1

⁹ *The Ladies Christian Home Constitution* para. 4.2

¹⁰ See : Chapter 4 hereof

Reference is made to one factor only. Although qualified marginally,¹¹ “the appointment, supervision and dismissal of staff” in a number of spheres and the “supervision and control” over the accountant,¹² lie within the authority of the General Manager.

3.3 Appointed Structure (Permanent)

- General Manager: the Board of Trustees has the power to appoint the General Manager.¹³
- Bursar: the General Manager, in terms of powers of general management, has authority to appoint a Bursar.
- Accounts Department: the Accounts department comprises the Treasurer/Accountant and the Bookkeeper. The activities of the accounts department including the supervision and control over the accountant fall under the authority of the General Manager¹⁴, while their appointments will fall under her powers of general management.
- Bible teacher and Religious visitor: the person appointed to conduct the Bible studies and attend to religious visitation is in an unusual position. He falls partly under the control of a church denomination and partly under the control and supervision of the General Manager under her powers of general management.
- Nursing Staff: there is one senior sister, three sisters and two staff nurses. There are twelve nursing assistants and twelve nursing aids. The nursing staff falls under the direct control of the senior sister but under the ultimate authority of the General Manager.

¹¹ *Ladies Christian Home Constitution* : para. 4.2.5

¹² *Ladies Christian Home Constitution* : para. 4.2.3

¹³ *Ladies Christian Home Constitution* : para. 4.2.1

¹⁴ *Ladies Christian Home Constitution* : para. 4.2.3.4

- Catering Staff: the kitchen supervisor is in charge of the catering staff which includes two cooks and comprises twelve persons in all. In addition, there is a handyman who does certain domestic duties and falls within the catering staff. The catering staff falls under the control of the General Manager.
- Maintenance Staff: there are two handymen which deal with the general internal maintenance. Maintenance beyond their capabilities is entrusted to outside commercial agencies. A gardener attends to the extensive gardens and there is a driver whose tasks are manifold. Appointment and supervision fall to the General Manager.
- Laundry Staff: there are two full-time laundry attendants and one who does casual or relieving duties. The General Manager controls their duties.

3.4 Appointed Structure (Part-time)

The part-time incumbents are no less a part of the structure because they do not fill a full-time role. There is a medical doctor; an occupational therapist; a physiotherapist; a podiatrist and a hairdresser. In terms of the Constitution, one *ex officio* Trustee respectively appointed by each of the following denominations, namely Baptist, Dutch Reformed, Church of England in South Africa, Methodist and Presbyterian, shall serve on the Board of Trustees.¹⁵ Certain of the ministers of these respective denominations form part of the social structure.

The researcher includes himself in the social structure in his capacity as a 'specialised visitor'. His role is undertaken on a voluntary basis and will be dealt with in various contexts.¹⁶

¹⁵ *Ladies Christian Home Constitution* : para. 4.1.2.2

¹⁶ *See Chapters Four, Twenty-five to Thirty-four*

3.5 Appointed Structure (Outsourced)

- Cleaning Staff: there is a cleaning staff consisting of a supervisor and four assistants. These persons, however, while forming part of the social structure, are not in the employment of the Ladies Christian Home. This service is outsourced to an external commercial agency who is responsible for the proper execution of the cleaning duties. It is the General Manager who monitors the cleaning staff and (if needs be) reports to the agency.

3.6 Non-appointed Structure

The residents are served by a weekly library service run by a librarian in the employment of the local authority.

3.7 Residents of the Home

The residents form the largest component of the social structure of the Ladies Christian Home. There are elements of unification present such as advanced age and institutionalisation. Unification does not, however, characterise this aspect of the social structure. While it constitutes a single aspect of the social structure, it cannot be dealt with in a simple descriptive exercise. Attention is therefore directed at the various elements of diversity.

Mention has already been made of the distinction that must be drawn between those who reside in the 'front part of the home' and those who reside in the 'back part of the Home'¹⁷. It is the difference between those who are more mobile, more physically able, and in some instances, more intellectually capable, and those who reside in the Frail Care Wing and, to limit the description, are less physically capable of engaging in the ordinary activities of day-to-day living.

¹⁷ See Chapter Two : *The Nature of the Investigation*

A further distinction is drawn between residents who are economically viable and those who are not. While no distinction is drawn between the care and attention metered out to the two groups, as a matter of fact, there are residents who are not dependent upon Government subsidisation and those who are.

According to Government policy, residents are graded according to their ability, both physical and mental, of coping with the ordinary process of living. A resident graded as I is determined to be the most capable of coping, while a resident graded as III is determined to be the least capable. Those who are financially non-viable and graded I receive no subsidy, while those who are graded III, and financially non-viable, receive the full subsidy. Accordingly, from the point of view of a social structure, differences exist according to the manner in which residents are graded.

The description of the residential sub-structure does not purport to be exhaustive. Probably, many more distinctions could be drawn. For instance, there are residents who are readily able to communicate and enjoy conversation, and other social activities, while there are others whose only means of communication is to respond (albeit feebly) physically by tactility. However, the principal distinctions have been drawn to indicate that the residents form an integral part of the social structure of the Ladies Christian Home but at the same time to show that they do not form a single, simple constituency.

3.8 Conclusion

This chapter has dealt with what may be described as the group of people which together, in their action and interaction, constitute the Ladies Christian Home. It did not purport to deal with what the respective social units do, or what contribution each part makes to the whole. This is the subject matter of the next chapter, and to this, attention is now drawn : 'The Institution: Its Social Function'.

Chapter 4. THE INSTITUTION : ITS SOCIAL FUNCTION

4.1 Introduction

Once again the terminology used is important, as it can be misleading.¹ What is meant by the social function of the Ladies Christian Home? It is not proposed to fit the question into an existing definition; nor is it proposed to formulate any new definition. It has already been observed that the Home is a social institution with a social structure.² Aspects of that social structure have been described.³ A social structure, however, is not an end in itself; its significance lies in providing an organised association wherein a particular social function can be performed, that is to say, a proper work can be accomplished or a particular purpose achieved. In this chapter, therefore, the Home will be observed as an operating institution within the framework of society.

Social function may be best understood by having regard to biological principles. In this regard, it is to be observed that biological organisms, confronted with a variety of environmental exigencies, must function in relation to these exigencies if they are to survive, and that specialised structures arise as adaptive mechanisms in this struggle.⁴ Applying this analogy to the functioning of society, it is to be observed that the concept of function involves the notion of structure consisting of a set of relations amongst unit entities, the continuity of the structure being maintained by a life-process made up of the activities of the constituent units.⁵

These things having been said, it is proposed to examine the social function manifested in the operation of the Ladies Christian Home. The starting point will be an observation of the functions which arise out of the constitutional situation. Secondly, observations will be made relating to the activities of the full-time

¹ See Chapter Three : Introduction.

² See Chapter Three: Introduction.

³ See Chapter Three: The Institution : Its Social Structure

⁴ Neil J. Smelser : *Handbook of Sociology* p. 106; *Societas* 7: *Sociologische Begrippen* 1-50 : Dian Joubert p. 23

⁵ Neil J. Smelser : (*supra* at fn 4) p. 108

appointed persons. Thirdly, the part-time appointed persons. Fourthly, the outsourced appointed persons. Fifthly, (as before), the “life-process made up of the activities” of the residents. Lastly, the social function exercised by the specialised visitor.

4.2 Constitutional Function

The Mission Statement declares :-

*“ . . . its primary concern is for ladies who are elderly, infirm and needy; to respect their rights, to accord them dignity, to attend to their welfare, and to ensure their freedom from danger, care, or fear . . . ”*⁶

The objects of the Home, *inter alia*, are stated to be :-

*“ . . . to provide a home for elderly and needy persons;
 . . . to provide for the sustenance, health and welfare of the residents of the Home;
 . . . to provide means whereby . . . encouragement may be given to the residents of the Home . . . ”*⁷

The Board of Trustees is invested with the “management government and general conduct of the affairs of the Home” and enjoined to “exercise all powers necessary and requisite for carrying out the objects of the Home”.⁸ The nature and scope of the functional role expected to be played by the Board of Trustees is clear.

Likewise, the functional role of the General Manager who is required to be “in sympathy with and supportive of the general principles upon which the Home is structured”.⁹ She is responsible for the general welfare of the residents and all the activities conducted in the Home¹⁰ as well as being required to manage the day-to-day affairs of the Home.¹¹

⁶ *The Ladies Christian Home Constitution para 2. See Chapter One : Introduction*

⁷ *The Ladies Christian Home Constitution para. 3. See Chapter One : Introduction*

⁸ *The Ladies Christian Home Constitution para. 4.1. See Chapter One : Introduction*

⁹ *The Ladies Christian Home Constitution para. 5.4*

¹⁰ *The Ladies Christian Home Constitution para. 4.2.2.*

¹¹ *The Ladies Christian Home Constitution para. 4.2.1.*

The Constitution does not, directly, provide for a functional role which includes visitation in any form, nor does it impose a functional duty upon any person to execute any role which approximates visitation. When regard is had to the Mission Statement, and the objects of the Home, there is certainly scope for such activity, both in its regular and specialised aspect.

4.3 Appointed Persons (Full Time)

The nursing staff, as has been indicated,¹² consists of sisters, staff nurses, nursing assistants and nursing aids. Their tasks are many and varied, but all, in one way or another, fulfil an important function. This function, which includes both the execution of menial tasks as well as more exalted ones, is invariably directed at the medical health, physical condition and mental state of residents. Moreover, if properly performed, the tasks are intense and demanding. While conversation and the exchange of dialogue between residents and nursing staff does occur, it is rarely of an intimate, personal or meaningful nature.

Moreover, the likelihood of meaningful conversation depends, to a very large degree, on the personalities of the respective participants and the nature of the relationship between the resident and the member of the nursing staff.

It is not excluded that in respect of certain levels of nursing staff and that in certain instances, meaningful dialogue, even in the case of personal problems, could occur. However, what is excluded, is the possibility of such dialogue being regular, systematic and continuous. It is, nonetheless, suggested that where a relevant problem is raised by a resident with a member of the nursing staff, it would probably be referred to the General Manager.

¹² See Chapter Three : Appointed Structure (Permanent)

The catering staff fulfils a very necessary function. Like the function of the nursing staff, however, it is directed at a particular end. That end is the physical state of the resident, not only from the point of view of a healthy body but from the point of view of a happy and contented state of mind. A bad 'table', apart from anything else, can lead to dissatisfaction and disquiet.

Furthermore, the opportunity for personal contact is limited, and the desire for discussion on any level, other than food, is not likely to present itself.

Strange as it may seem, there is a cordial relationship between the maintenance staff, and the driver, and many of the residents. This is not without reason. The driver is an employee of longstanding. Over the years, he has endeared himself to many of the residents through the driving operation. He is invaluable to the efficient functioning of the Home, and he is invaluable to the residents who rely upon his efficiency and expertise. Likewise, the chief maintenance official. He has an excellent rapport with many of the residents. Also, not without reason. From the maintenance point of view, he (sometimes assisted by outside commercial agencies) makes the physical structure 'work'. Like the driver, he makes an inestimable contribution to the social function of the Home. At the expense of too much detail, a general statement is made : the maintenance staff as a whole, as a part of the social structure makes a considerable contribution to the efficient functioning of the whole.

At the same time, its function is directed towards the particular end of maintenance, which, obviously, includes the interests of the residents, but it does not lend itself, however valuable the function may be, to dealing with the personal problems, difficulties, and joys of the residents.

4.4 Appointed Persons (Part-Time)

There are three persons, or groups of people, who, more so than any others, have opportunities, in fulfilling their functional role, to minister to the private and personal needs of residents. One is the Bible teacher and spiritual minister¹³. He attends the Home one morning a week, during which he gives a Bible study for half-an-hour, and thereafter, for about two hours, he visits the residents. These visits are directed predominantly at the residents who are in the Frail Care section, or residents who are ill or dying. His contribution to the functioning of the whole is important, and cannot be minimised or decried. But it suffers inherent shortcomings. His visits take place only once a week and then only for a short period of time. His opportunity to cover a wide field or make in-depth observations are very limited. Moreover, he is viewed essentially in a religious light which may be a restricting factor.

The second is the group of ministers who conduct services of worship in the Home and exercise a visitation ministry.¹⁴ This is largely confined to one half-hour service conducted once a week by each of the ministers of the respective denominations, and followed (occasionally) by limited acts of visitation. In addition, there are other visits by denominational ministers to residents who belong to that particular denomination. This is a very confined function, and to all intents and purposes is no more than a conducting of a service of worship for a half-an-hour per week. It could be a very vital function from the point of view of visitation, albeit on a denominational basis, but it is not. It is too irregular, and of too short a duration to make any impact. It is lacking in the essential ingredient of 'specialised visitation', namely 'continuity and regularity'.¹⁵

The third person is the medical doctor. He is actually a District-Surgeon who calls once-a-week to attend to financially dependent (pensioner) patients. By way of explanation, it must be said that in respect of economic patients, arrangements are

¹³ See Chapter Three: Appointed Structure (Permanent)

¹⁴ See Chapter Three : Appointment Structure (Part-time)

¹⁵ See Chapter One : Introduction

made to see a medical doctor, for whose services the resident pays, either personally or by way of some medical-aid scheme. The limited role of the medical doctor is all too obvious. This is not a reflection on his or her medical ability but simply on the limitations of time and costs. The social function played by the medical doctor is important but to extend it to incorporate the function and role of 'specialised visitation'¹⁶ is, it is suggested, taking the medical role too far.

Mention may be made of the social functions played by the physiotherapist, the podiatrist, and the occupational therapist. Each plays a vital role and each makes an important contribution to the functioning of the whole. At the same time the functional role of each is directed at a particular end. Moreover, time is a limiting factor; as is the question of cost. Their visits are regular, but essentially from time to time; in some cases, as much as twice a week, while in other cases, several weeks may pass without making a visit. The essential criterion to qualify as 'specialised visitation', namely, 'regularity and continuity' is absent.

Without derogating from the functional role they play, it is not proposed to comment too widely on the librarian and the hairdresser. By and large, the librarian functions 'at a distance', in the sense that she chooses books and sends them to the residents, while the hairdressing salon is hardly a place for intimate, problematic and personal talk. The simple point that is made is that the functional roles do not impinge upon the nature and function of 'specialised visitation'.

4.5 Appointed Persons (Outsourced)

For the sake of completeness reference is made to the cleaning staff.¹⁷ From the eye of the casual observer the status of the cleaning staff is not likely to rank very highly in the social structure of any social institution. Its social function, however, cannot be overemphasised. The cleanliness and odour of an old-age home is often the hall-mark by which the entire operation is judged. But be that all as it may. The

¹⁶ See Chapter Two : *The Purpose of the Investigation*

¹⁷ See Chapter Three : *Appointed Structure (Outsourced)*

cleaning staff come into regular and close contact with the residents and they are held in high regard by them. Nonetheless, there is no indication of any close contact in the sense of discussions between them on an intimate, personal level. There has been no suggestion of such a discussion having taken place and it is highly unlikely that it should have.

The function of the cleaning staff is clearly understood by each member and carefully monitored by the administration. The fact that this is an outsourced function¹⁸ does not lend itself to any form of personal engagement between cleaning staff and residents.

4.6 Residents

It has been observed that there are elements of unification which unite the body of residents; at the same time they do not form a single, simple constituency.¹⁹ In all probability, it is correct to say that they form a disconnected arrangement of unique individuals who come together for various purposes.

There are two large, well-furnished lounges but these are rarely the meeting places of more than one or two residents at any particular time, save in special circumstances. Friendships are formed and visitation does occur among the residents but this is the exception rather than rule. At any given point in time, the vast majority of residents can be found in their rooms, either reading or just sitting or, occasionally, sleeping.

There are exceptions to this general observation. On Monday mornings the Bible Study is held in the TV room.²⁰ Some twenty to thirty residents attend. On Tuesday mornings a service of worship is held in the TV room.²¹ This is attended by about forty to fifty residents. According to the wish of the presiding minister, a tea is

¹⁸ See Chapter Three : Appointed Structure (Outsourced)

¹⁹ See Chapter Three : Residents of the Home

²⁰ See : Chapter Three : Appointed Structure (Permanent); Chapter Four: Appointed Persons (Part-time)

²¹ See: Chapter Three : Appointed Structure (Part-time); Chapter Four : Appointed Persons (Part-time)

served in one of the lounges. About fifteen to twenty residents attend the tea party with the minister. On Wednesdays, free transport is offered to residents who are mobile and physically able, to a local shopping centre to make minor purchases, and to attend to aspects of business such as banking. In the interests of residents, this activity is carefully monitored and some twenty to twenty-five residents participate. On Thursdays, exercises are offered to the residents by the occupational therapist. A small group attends. The occupational therapist also arranges other activities; every second Friday Bingo is played in the TV lounge where about twenty-five people share in the activity. On the other Friday, other activities, such as card-making, chocolate making and games are on offer. Small groups of eight to fifteen residents partake.

A limited amount of activity is offered to the residents in the Frail Care Wing. Apart from the various gatherings of residents as indicated, the overwhelming tendency is towards individualization. Even when specialised activities such as music concerts or performances or outings by the Lions or Rotary Anns are offered the response is diffident and a good response expresses itself in a group of residents numbering between fifteen and twenty-five.

By and large the social function of the Home is to a very large extent directed at the individual rather than the constituency of residents.

4.7 The Administration

The social function of the administration is immense. So much so that it is treated as a separate topic in the next chapter.

4.8 Specialised Visitor

Although it will be dealt with in some considerable detail presently, for the sake of completeness, the social function of the specialised visitor is briefly addressed at this stage.

The role of the individual resident is important. Much of her time is spent alone; much of her activity is performed alone or in small groups; her participation in large groups or with numerous people is limited or non-existent.

The 'specialised visitor' performs his social function to the resident in her 'aloneness'. Despite the fact that the tendency is not to seek friendship or company, the resident is always open to visitation by the 'specialised visitor' and invariably he is warmly welcomed. The 'specialised visitor' meets with the resident without interruption and in confidence. On many occasions, the 'specialised visitor' meets the resident at a point in time when she wishes to talk; or to express confidentialities; or to make known needs or concerns; or to reveal joys and happinesses.

If his social function is to be generalised, it is 'availability'. The 'specialised visitor' comes to listen, and if invited, to talk; he has no limits as to time and no costs are involved. He comes as an individual to the individual; he is not supervised by the management; and though he owes a duty to the Board of Trustees, the subjects of discussion are confidential.

4.9 Conclusion

In the discharge of its social function all manner of provision has been taken to give to the resident as good a quality of life as her age and physical and mental condition will permit; medical, physical, mental, food and sustenance, maintenance of 'hearth and home', transport, spiritual welfare, obviation of boredom and entertainment, and so on. The one glaring omission seems to be the meeting of the resident at her point of need and 'aloneness'. Hitherto, this has been the role and function of the administration. Accordingly, attention is now directed to "The Institution: Its Administration".

Chapter 5. THE INSTITUTION : ITS ADMINISTRATION

5.1 Introduction

The administration of the Ladies Christian Home occupies a vital position in its social structure and plays a pivotal role in its social function. The point is made but emphasis will not be inapposite. The administration is the nerve centre of the whole operation. Constitutionally, the Board of Trustees occupies a position of authority and control ¹, but practically speaking, the administration is the centre of activity, the mainspring of achievement, and the source of accomplishment. Hence it being dealt with under a separate head.

The social function of the administration will be dealt with in some detail. At this stage a preliminary observation may be made. The function of the administration is two-fold: the first relates to the general management of the Home, which includes the business, financial and commercial aspects thereof. The second is less mundane; it relates to helping and to offering succour and aid to the residents, it relates to the welfare and security of the elderly, it relates to their encouragement.² The importance of this role cannot be said to be of greater importance than the other; but what can be said is that it is not of lesser importance. It will be dealt with.

Also in its store house of treasures, the administration possesses a vast knowledge of the social structure, and in particular, a vast and intimate knowledge of each of the residents. Their physical and mental condition, their special attributes and peculiarities, their individual characteristics and qualities are all ascertainable from the administration. This is of enormous benefit to the 'specialised visitor'.

¹ *The Ladies Christian Home Constitution : para. 4.1.1*

² *The Ladies Christian Home Constitution : paras. 2 and 3*

5.2 Composition of the Administration

For the magnitude of the operation, the size of the administration is small. The full complement of the residents numbers one hundred and twenty, and there is a staff of over fifty. The administration comprises three full-time employees, and two part-time appointments. The terms ‘full-time employees’ is misleading in this sense that while they occupy permanent positions on the staff, they do not work full days. Technically, they are employed from 08:30 to 12:30 but in fact, they are often at their desks until mid-afternoon. One part-time employee performs professional duties from time to time during a month, on an hourly basis. The other part-time appointment does sporadic administrative duties on a voluntary basis.

The head of the administration is the General Manager who is appointed by the Board of Trustees in terms of their Constitutional powers.³ The Bursar is appointed by the General Manager in terms of her powers of general management.⁴ Likewise, the Treasurer/Accountant and the Bookkeeper are appointed by the General Manager in terms of her general powers.⁵

The appointee on the voluntary basis is the ‘specialised visitor’ who by reason of his special expertise in spheres other than visitation, is required to perform certain functions of a specialised nature, from time to time.⁶ This appointment was made in terms of general powers by the General Manager and later confirmed by the Board of Trustees.

5.3 Function of the Administration

The social function performed by the General Manager covers a wide ambit. If there is a difference between the two requirements, she is required to manage “the day-to-day affairs of the Home”, and “to attend to the ordinary, normal and general

³ *Ladies Christian Home Constitution : para. 4.2.1. See Chapter Three : Appointed Structure (Permanent)*

⁴ *See Chapter Three : Appointed Structure (Permanent)*

⁵ *See Chapter Three : Appointed Structure (Part-time)*

⁶ *See Chapter Three : Appointed Structure (Part-time)*

activities of the Home.”⁷ She is “responsible for the general welfare of the residents and all the activities conducted in the Home”.⁸

The authority of her general management extends to the operation of the Frail Care Wing, the entire ambit of the catering operation, the house-keeping operation, and the activities of the accounts department.⁹ Included in the aforementioned functions are the additional duties of the appointment, supervision, dismissal and disciplining of staff members, and the supervision and control over the accountant.¹⁰

She is required to prepare a monthly report and profit and loss account and submit these together with an agenda to the ordinary meeting of the Board of Trustees.¹¹ Furthermore, the General Manager is required to “be one who is in sympathy with and supportive of the general principles upon which the Home is structured”.¹²

The particular social function to which attention will be directed, not only in relation to the General Manager but also to certain other members who comprise the administration is the responsibility “for the general welfare of the residents”.

The social function performed by the Bursar, similarly, covers a wide ambit. Her function and role is not determined or defined by the Constitution. Indeed, her position and task are not even alluded to in the Constitution. Rather, it has grown and developed with the passage of time, as needs, demands and challenges have presented themselves from time to time. Two distinctive directions have manifested themselves : one is towards a purely business or professional end while the other is towards the end of the ‘general welfare of the residents’. The former relates to the receipt of the monthly board and lodging, the payment of the balance of the monthly pension (with attendant formalities required by the Department of Social Services), the preparation of monthly salaries to be paid to the staff (done in

⁷ *The Ladies Christian Home Constitution : para. 4.2.1.*

⁸ *The Ladies Christian Home Constitution : para. 4.2.2.*

⁹ *The Ladies Christian Home Constitution : para. 4.2.3.*

¹⁰ *The Ladies Christian Home Constitution : para. 4.2.3.*

¹¹ *The Ladies Christian Home Constitution : para. 4.2.4*

¹² *The Ladies Christian Home Constitution : para. 5.4.*

collaboration with the bookkeeper), meeting, when occasion demands with the Government Social Worker (and completing such formalities as are required), attend to all the requirements of the Staff Provident Fund, and so on.

The latter relates to a more time-consuming and demanding aspect of the administration's social function; it relates to a more sensitive, tender and compassionate aspect of administration. It relates to the Bursar meeting a resident at her point of immediate need; a need which cannot be met by the resident because of physical frailty, mental inadequacy, or a lack of opportunity to do what requires to be done. Jewellery, money and documents must be stored in the Home's safe (and taken out when required); petty cash, pocket money and church contributions need to be withdrawn; indigestion tablets, hearing aid equipment and radio batteries must be obtained; aerograms and stamps must be available, and parcels must be collected from the Post Office. These mundane, even trivial, matters could be multiplied but neither time nor opportunity permits.

To this can be added the need to help residents with their financial problems, fill-in their medical aid forms, giving change many times a day (and every day), listening to multitudinous problems, and offering comfort, solace and strength according to the needs revealed.

The obvious answer to this multiplication of personal duties is to streamline the whole operation and become more efficient. This may mean a determination of particular days upon which various aspects of business will be transacted, or the limitation of the hours of a day during which the Bursar may be approached. But this is to promote efficiency above personal need; this is to overlook the fact that certain of the residents cannot tell one day from another, or whose only appreciation of time relates to breakfast, lunch or supper time. This is to emphasize 'general management' at the expense of the 'welfare of the residents'.

At the expense of repetition, the social function to which attention is directed is the responsibility of the administration "for the general welfare of the residents".¹³

¹³ See above and *Constitution of the Ladies Christian Home* : para. 3

The social function performed by the bookkeeper is, primarily, to produce the monthly financial statements. She also fulfils the role, each month, of taking stock in the kitchen. The bookkeeper works in close collaboration with the Bursar. She assists the Bursar in the telephone-answering exercise, as also in the preparation of salaries. Her identification with the Bursar extends to a close contact with the residents. When the Bursar is away or otherwise engaged, the bookkeeper adequately fulfils the role of attending to the personal requests or demands of the residents; indeed, she is more than willing to lend a listening ear to the plaintive cry of a resident and to offer her advice in circumstances where such is sought. Manifestly, she does not consider her role to be purely commercial or financial, nor do the residents. In performing her social function, the 'welfare of the residents' plays an important part.

Four things need to be said of the Accountant. Firstly, he is a professional man who renders to the Home a professional service of the highest degree of competence. Secondly, he fulfils the function of supervising and overseeing the role played by the bookkeeper. Thirdly, he has a vast and intimate knowledge of the function and role played by 'old age homes'. Fourthly, he is deeply committed to the welfare of the aged and enthusiastically supportive of all means directed at improving the quality of life of elderly people. Not the least of this is his encouragement of the 'specialised visitation' programme.

Attention is now directed at the social function of the 'specialised visitor' in the execution of activities other than that of 'specialised visitation'. He too is a professional man of considerable experience in the legal field. This qualifies him to deal with matters relating to the disciplining of employees in the context of labour legislation. He is able to interpret and apply legal measures as they apply to the operation of the Home. He is required to draft letters which go beyond the scope of normal and accepted management. Likewise, he is required to deal with matters, or offer his advice thereon, where management needs his expertise. He is not part of the management, nor indeed, of the administration; to the best of his ability he does

not intrude therein; and only participates where he is invited so to do. In his assessment, his more valuable contribution to the social function of the Home, is his engagement with residents who seek his advice and guidance on all manner of matters. He does not hold himself out as a lawyer giving legal advice. Rather, he meets with residents simply to offer his counsel, suggestion and recommendation in the face of the varied problems they may raise.

5.4 The Location of the Administration

Whether by accident or design, the four offices occupied by the administration are situated on the ground floor. Moreover, they occupy a strategic position. They are near the lift which conveys residents from the first and second floor to the ground floor and thence, to the dining room, the TV room, the lounge, and the garden. For the greater part of the 'front of the Home' resident, they must pass the offices of the administration a number of times a day. Indeed, they lend themselves to visitation on the part of the residents. This is all the more so, when regard is had to the 'open door' and 'open hour' policy of the administration.

From the point of view of imposition by the residents, it may be regarded as incompetence or bad planning. But this is not the case. The Home is for the residents, and not the residents for the Home. In the Mission Statement, it is declared:

*"Its (the Home's) primary concern is for ladies who are elderly, infirm and needy . . ."*¹⁴

In keeping with its objects, the Home is providing for the sustenance, health and welfare of the residents of the Home.¹⁵

¹⁴ *The Ladies Christian Home Constitution : para.2*

¹⁵ *The Ladies Christian Home Constitution : para. 3*

5.5 The Emphasis of the Administration

If the General Manager is required to be a person who is in sympathy with and supportive of the general principles upon which the Home is structured¹⁶, and if she is to give impetus to the administration which falls within the sphere of her general management authority¹⁷, then the question arises as to what the nature of these general principles is, as it must ultimately determine the emphasis of the administration. The answer to the question lies, firstly, in an examination of the provisions of the Constitution, and secondly, in an examination of the manner in which the administration conducts itself.

The primary concern of the Home, as set forth in the Mission Statement¹⁸ sets the standard by which the emphasis of the administration must be gauged i.e. “. . . infirm and needy . . . accord them dignity . . . attend to their welfare . . . freedom from danger, care, or fear.” The objects of the Home, as set forth in the Constitution¹⁹ is no less demanding i.e. “. . . elderly and needy persons . . . welfare of the residents . . . whereby . . . encouragement may be given to the residents . . .” To go no further with the Constitutional provisions of the Home it is clear that the general principles upon which the Home is structured directly relates to the quality of life of the elderly.

And this is the manner in which the administration conducts itself. In one sense, it is a commercial undertaking in that, for survival, the books must be balanced; assets must exceed liabilities; and salaries must be paid. But its commercial nature is not its primary quality. The administration fulfils its social function not in the professional or business sense of the word; it does so rather as a vocation or calling, where the problems and needs of the aged and infirm are dealt with as a mission, and not as a charge-per-hour.

¹⁶ *The Ladies Christian Home Constitution* : para. 5.4.

¹⁷ *The Ladies Christian Home Constitution* : para. 4.2.

¹⁸ *The Ladies Christian Home Constitution* : para. 2. See Chapter One : Introduction; Chapter Four : Constitutional Function

¹⁹ *Ladies Christian Home Constitution* : para. 3. See Chapter One : Introduction; Chapter Four : Constitutional Function

5.6 The Administration and Personal Contact

Having dealt in some measure with the social function of the administration, albeit cursorily and superficially, and having said that its commercial nature is surpassed by its humanitarian commitment, it remains to be said that the mundane and pragmatic aspects of administration are very demanding, and becoming increasingly so. The departmental demands; the requirements of salaries and wages; provident funds; absenteeism; payment of pensions, and so on, are time-consuming in the extreme.

The obvious effect of this is that the scope for personal engagement has become very limited, and with the passage of time and the increasing demands of matter-of-fact administration, is becoming more limited.

This has had an alarming effect on the administration in its quest to give time and energy to effective personal contact with the residents. The administration will readily admit that it is gradually losing touch with the 'primary concern' of the Home and not achieving what is demanded by 'the general principles upon which the Home is structured'. In many respects, it concedes a measure of failure in that area of the administration which it considers as all-important, namely, enhancing 'the quality of life of the elderly'.

5.7 The Administration and the Specialised Visitor

The administration understands and supports the social function of the 'specialised visitor'; indeed it sees the character and role of the 'specialised visitor' as an extension of its own character and role, fulfilling the role and function that, in ideal circumstances, would normally fall to it. Accordingly, the administration works in regular and close co-operation with the 'specialised visitor'.

It furnishes him with regularly updated lists of residents; it furnishes him with updated lists of the birthdays of residents, so that he can visit them and give a birthday card and small gift prepared by the administration; and it furnishes him with information regarding the state or condition of a resident.

Where the administration encounters difficulty in regard to the affairs of a resident, it enlists the aid of the 'specialised visitor'. The role of the 'specialised visitor' cannot be divorced or separated from the administration, and to a very large degree, complements the humanitarian aspect of the administration's work.

5.8 Conclusion

The social function of the administration, in its differing facets, concludes the investigation into the social function of the institution. Attention is now directed at Section C which examines the Ladies Christian Home from the point of view of the process of institutionalisation. In Chapter 6 the institution and the process of institutionalisation are considered, while in Chapter 7 observations are made concerning the nature, function and purpose of institutionalisation. This process follows a demanding and difficult course which must be approached with understanding and sympathy.

SECTION C. INSTITUTIONALISATION**Chapter 6. THE INSTITUTION AND THE PROCESS OF INSTITUTIONALISATION****6.1 THE INSTITUTION**

The physical structure which houses the Ladies Christian Home has been enlarged from time to time over a hundred years ¹, and is not inconsiderable in its worth. However, the physical structure, whatever its worth, is not an end in itself. The social structure has likewise enlarged and diversified over the years ². The social structure, similarly, is not an end in itself. They are both means to an end.

In like vein, the assets of the Home, are reflected in monetary terms in the balance sheets. As a matter of fact, divorced from the social function of the Home, they have no value. Indeed, the Constitution lays down that any net assets “shall not be paid to or distributed among any of its members or trustees, but shall be transferred to such other charitable, ecclesiastical or educational institution . . . as may be decided by the . . . trustees . . .” ³. The assets only have value when they are used for the objects for which the Home was founded. ⁴

Moreover, the constitutional nature of the Home is not such as to provide for dividends to be paid to shareholders out of profits, nor does the Constitution provide for any remuneration to be paid to trustees. Historically and constitutionally the prime objectives arise out of or are related to the institution and the process of institutionalisation.

If one is to go to the historical roots ⁵ and analyse the motivation that inspired Mrs Lion Cachet to move for the establishment of an institution, the following picture emerges :-

¹ See Chapter One : Background

² See Chapter Three : The Institution : its Social Structure

³ The Ladies Christian Home Constitution : para. 10.2

⁴ The Ladies Christian Home Constitution : paras. 2 and 3

⁵ See Prolegomena para. D; Chapter One : Background; The Story of the Ladies Christian Home pp. 1 and 2

- a) visits among the poor
- b) the sad condition of elderly ladies living in reduced circumstances
- c) the need for a home for the reception of aged, infirm and indigent ladies
- d) where they should be received, lodged and fed.

At any particular point in time, during the long history of the Home, the same picture presents itself ⁶. This historical narrative repeatedly refers to a “Home”, to “elderly ladies”, to “their welfare” and in the final analysis, to an improved and enhanced quality of life ⁷. It is not a hospital ⁸, nor is it a nursing home, although the historical records indicate that, in the past, it has been used for this purpose ⁹. It is a home, the primary concern of which is “for ladies who are elderly, infirm and needy to attend to their welfare and to ensure their freedom from care, or fear ¹⁰. But it is more than a home for the elderly. The state and condition of the elderly do not remain constant. The old get older; the infirmity of the infirm intensifies; and the needs of the needy increase. Thus it is a home for those who need a home; and a frail care for those whose needs have become greater with the progression of the years.

The concern of the institution is inseparably linked to the condition of the resident. This condition, obviously, varies from resident to resident; it may be no more than the fact of old age, without any attendant mental, physical or other deficiency. On the other hand, it may be the fact of old age (relatively speaking) linked to the onset of recurring forgetfulness or Alzheimer’s disease or lack of mobility. But whatever the condition, unless there is a corresponding concern, the institution fails in its objective. A disregard of, or insensitivity towards, the condition of a resident, cannot achieve an improved quality of life for that resident. Relating more specifically to the Ladies Christian Home, it cannot ‘provide for the sustenance, health and welfare of the residents of the Home’ ¹¹.

⁶ See Chapter One : Introduction : The Ladies Christian Home Constitution : paras. 2 and 3

⁷ See Chapter Four : Constitutional Function; and Chapter Five : The Emphasis of the Administration

⁸ The Minute of the meeting of the Board of Trustees dated 27th October 1999 stated “that the Ladies Christian Home is not a hospital and therefore the Home would continue the policy of not admitting bed-ridden patients”

⁹ The Story of the Ladies Christian Home (supra) p. 4 : See : Chapter One : Background

¹⁰ The Ladies Home Constitution para. 2. See : Chapter One : Introduction

¹¹ The Ladies Christian Home Constitution : para. 3.2

Moreover, this concern cannot be allowed to become static; it must be an active, energetic and forceful concern. It must keep abreast, indeed, ahead, of the ageing process; it cannot be impatient with those who recurrently forget, or eat badly, or soil their clothes. The condition may be dire but the concern must be sympathetic and sensitive, so as ‘to accord them dignity, to attend to their welfare, and to ensure their freedom from danger, care, or fear’¹².

Likewise, the concern of the institution cannot be too ‘down-to-earth’. It must, on all levels of the social structure, and all aspects of the social function, express itself in a gentle, calm and caring attitude, that in ‘all its endeavours it is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares’¹³.

This ‘caring attitude’ has been dealt with at some length with an emphasis being placed on the manner in which the administration conducts itself, as also, on the nature of the calling of those who, in their respective spheres, fulfil the various positions they occupy in the administration¹⁴.

The institution cannot be separated or divorced from the process of institutionalisation, and the process of institutionalisation cannot be separated or divorced from the institution. The two belong to each other. By definition, an ‘institution’ is a ‘society or organisation established for some object, especially cultural, charitable, or beneficent, or the building housing it’¹⁵, and ‘institutionalise’ is to ‘bring up in an institution or to subject a person to institutional life’¹⁶.

Under this head, three subjects are being viewed, not two; one is the ‘institution’, the other is the ‘process of institutionalisation’, and the third is the *ethos* or characteristic spirit of the Ladies Christian Home.

¹² *The Ladies Christian Home Constitution : para. 2*

¹³ *The Ladies Christian Home Constitution : para. 2*

¹⁴ *See Chapter Five : The Emphasis of the Administration*

¹⁵ *Chambers's Twentieth Century Dictionary*

¹⁶ *The World Book Dictionary*

6.2 THE PROCESS OF INSTITUTIONALISATION ¹⁷

The nature, function and purpose of institutionalisation will be investigated in a separate chapter ¹⁸. At this stage, it is proposed to deal with certain facets of the process in order to appreciate, in general terms, what is envisaged by the process.

In the first place, the process of institutionalisation must be seen in relation to the condition or state of the person being institutionalised. ¹⁹

This condition may be no more than the ordinary, normal manifestations of advanced age. On the other hand, it may encompass a distinct physical or mental deterioration which may, or may not, relate to a state of advanced age. The fact of the matter is that the condition of a resident, whatever that condition may be, must be carefully assessed and taken into account in the process of institutionalisation.

In the second place, the motivating factors giving rise to the process of institutionalisation must be analysed and assessed. Is it the resident who is seeking institutionalisation, or, at the very least, is party to the process? Or is a part of a 'dumping' process on the part of the family in their own selfish interests? In fact, motivation is a very important matter. In the end, the question must be asked: in whose interests is the initiation (and culmination) of the process of institutionalisation occurring?

In the third place, the fact of institutionalisation must be seen as a process of extraordinary change. This involves an understanding and appreciation of the former situation linked to the new situation by a process of change which can have far-reaching repercussion.

¹⁷ The meaning attributed to this process is to be distinguished from 'making into or treating as an institution'. See: *World Book Dictionary*; Neil J. Smelser : *Handbook of Sociology (supra)* p. 125. This definition is accepted and approved by sociologists. It refers to the establishment of common routines and understandings. They come to be "externalised" insofar as they become to be represented as objective reality, most notably in their transmission through socialization to future generations. See also: *Societas 7 : Sosiologiese Begrippe 1-50* : Dian Joubert p. 34

¹⁸ See Chapter Seven

¹⁹ See : Hess and Markson : *Aging and Old Age (supra)* p. 153

In the fourth place, there must be an explanation and appreciation of very different conditions to those which formerly existed. Whichever way the matter is viewed there is an element of regimentation, control and order which suddenly becomes part of the resident's lifestyle. Moreover, there is an element of limitation in relation to the resident's room, the common dining room, lounge and bathroom. This limitation extends to the resident's contacts, friends, the association with the family, the ability to go shopping, and attend to banking matters.

In the fifth place, the question of adaption to a new situation is not without significance. This applies not only to a physical and mental adaption, but also an emotional adaption, which in a number of situations can be critical.

As a sixth consideration, there is the question of reaction, reaction to domestic and nursing staff, reaction to other residents, some of whom may suffer from various shortcomings and deficiencies, reaction to the administration, with whom they must come in regular and close contact, sometimes in the sphere of a form of control and discipline. Often the reaction to family members can give rise to disquiet and displeasure.

A seventh consideration to which residents react in differing ways, is the fact of intrusions into their lifestyle, to the extent of a limitation of a resident's privacy. In one way or another, there are intrusions by staff and employees in the discharge of their domestic duties; there are intrusions by the nursing and medical staff.

This leads to the eighth consideration; the need for confidentiality on a number of levels. There is the level of there being available someone in whom they can put their trust; there is the level of there being available someone to whom the resident can talk, if not of a confidential nature, then, at least, of a serious nature. Someone must be available to whom they can, with confidence, make private and personal disclosures.

This leads naturally to the field of the ‘specialised visitor’ but before attending thereto there is a ninth consideration to which attention must be given. Institutionalisation, in the vast majority of cases, gives rise to the last major move a resident is likely to make. Depending on the age and condition of the resident, the next stage to be faced is that of death. Death is a reality of life, but it is suggested, it becomes more real as the years go by. Sooner or later, the person of advanced age, must face this reality, either privately, or in discussion with someone, and if sought, appropriate counselling should be available.

The tenth consideration relates to the process of institutionalisation and the role of the ‘specialised visitor’. And from a number of points of view, not the least of which is his availability. This is linked to the fact that he is not bound by any time restrictions or administrative commitments. His visits are regular and continuous. Moreover, the systematic programme of visitation lends itself to familiarity, friendship and a bond of confidentiality.

6.3 CONCLUSION

As an overview, the institution has been examined in relation to the process of institutionalisation. Certain facets have been highlighted and emphasised, not the least of which is the role played by the ‘specialised visitor’ in the context of the institution and the process of institutionalisation. In fact, the role played by the ‘specialised visitor’ arises out of, and is an integral part of both the institution and the process of institutionalisation. So much so that the process of institutionalisation warrants closer investigation in coming to terms with an appreciation of the concept of ‘specialised visitation’. Attention is accordingly drawn to the subject “The Nature, Function and Purpose of Institutionalisation.”

Chapter 7. THE NATURE, FUNCTION AND PURPOSE OF INSTITUTIONALISATION

7.1 INTRODUCTION

It has been observed that the process of institutionalisation is inextricably bound up with the role played by the 'specialised visitor'. Indeed, within the context of the investigation being undertaken, there would be no need for any role to be played by the 'specialised visitor', nor any need for the practice of 'specialised visitation', without the process of institutionalisation. The contention will be advanced that it is the facts and circumstances surrounding the institutionalised resident that gives rise to the need for a 'specialised visitor' and the operation of 'specialised visitation'.

If such great importance attaches to 'specialised visitation' in the context of institutionalisation, it follows that the nature, function and purpose of institutionalisation stands to be investigated in greater detail than the overview that has already been undertaken ¹.

7.2 THE NATURE OF INSTITUTIONALISATION

The process of institutionalisation can begin with a thought, an idea, a notion in the mind of a person. What gives rise to this thought, this idea, this notion is difficult to say, as it varies from person to person. In most cases it arises out of a particular state or condition which manifests itself in the life and experience of the person concerned. It may be no more than the advancement of age, when a person says to herself that the time has come for her to give up her home and move into the security of an 'old age home'. It may be something more radical, like a deterioration in the physical or mental state of the person. When she can no longer cope with her existing situation, she determines to find refuge in a home for the elderly.

¹ See Chapter Six : *The Process of Institutionalisation*

It may be that the initiation of the process has little or nothing to do with the person concerned. It is the suggestion or action of some third party, such as a son or a daughter or other relative, that sets the process in motion. In most instances this is an action taken in good faith and in the best interests of the person concerned. In other instances, sinister motives can be detected. A child or a family sells the house, divides the 'spoils', obtains a pension, and institutionalises the 'victim'. But whatever the motive, the starting point of the process usually arises out of the state or condition of the person in question. By and large, it is a frailty of body, a deterioration of mind, leading to an inability to cope with an existing situation, and requiring some form of institutionalisation.

The nature of institutionalisation manifests itself as a process which occurs over a period of time. This period of time can be a matter of months, or it can be a matter of years. It starts with the initial thought, idea or action and culminates on the day that the threshold is crossed and a room is occupied in an institution. Moreover, it is a process which embodies more than a mere passage of time; it involves considerable heart-searching, painful emotions, indecisive actions, and angry words. Many have been the occasions when the process has been initiated, only to be aborted thereafter.

Institutionalisation invariably involves a locality move, a matter which can have far-reaching consequences. Where the locality of the Home is distant from the locality of family and friends, it can lead to the isolation of the resident, infrequently visited, and sometimes forgotten. On the other hand a convenient locality can lead to frequent visits, a consolidation of relationships, and a favourable and continuing connection.

What is frequently a matter of deep emotion and considerable heartbreak, but is nonetheless an integral part of an understanding of the nature of institutionalisation, is the continued possession of personal and precious items. The rooms of the Ladies Christian Home are furnished but the policy of the Home is to allow residents to furnish rooms with their own furniture and sentimental items. This, of course, is subject to the size of the room.

Allied to the furnishing of rooms are the matters of settling into the Home and surroundings, and adjusting to the new environment. This is sometimes easily accomplished; sometimes accomplished with considerable grief and many tears; and sometimes not accomplished at all. Moreover, without painting too vivid a picture of immutable authority and control, there is the need to submit to a set of rules of conduct, and to a measure of order and discipline. This may well have been absent in the situation that previously prevailed, and may require considerable effort to comply.

The nature of institutionalisation necessarily involves a significant role on the part of the administration. It must always be mindful of the state or condition that pertains to the resident and devise ways and means whereby this state or condition can be controlled to the benefit of the resident and to other residents not similarly afflicted. First and foremost, it must make the resident feel at home, not only in relation to the administration but also the nursing staff, the domestic staff, and other residents. Through regular and continuous contact with the resident, she must be absorbed into the body of the institution; she must be comforted, strengthened and encouraged; and any problems that may arise must be sensitively smoothed-out.

The administration must assume control of the finances of sub-economic residents, maintain a close contact, and, if possible, a good relationship with members of the family of the resident, or the person in control of her affairs; and encourage the resident to build-up social relationships within the institution and engage in acts of visitation to other residents. A sensitive administration will go to the extent of positioning the resident at an appropriate table for meals so that her institutionalisation will be a pleasure and not a hardship.

7.3 THE FUNCTION OF INSTITUTIONALISATION

Basic to the function of institutionalisation is, firstly, the provision of a room with furniture, or if not with furniture, then the opportunity to furnish the room with sentimentally precious items. Secondly, there is the provision of three meals a day.

The use of the word 'meals' is done so advisedly, as a mere plate of food, neither nutritious nor attractively prepared and presented, can be a cause of dissatisfaction and a yearning for the pre-existing state of affairs. Thirdly, there is the matter of hygiene. This entails the provision of clean, adequate bathrooms and toilets and, where necessary, the assistance to properly use these facilities. The matter of clothing is noted so that residents should look good, not only to themselves but to the other residents. Where residents are incontinent, appropriate provision should be made, not only for their own comfort and pride, but also, that others should not be offended. Fourthly, the provision of efficient laundry arrangements and procedures must be in operation.

While on a different level, medical care is also basic to the function of institutionalisation. The availability of a doctor at regular defined intervals, and the constant (day and night) attendance of nursing facilities are regarded as essential.

Included in medical care, is the provision of means to be taken (and admitted, if necessary) to hospital and the dentist. These were all facilities which were previously available and cannot be neglected or avoided in the institutionalised situation.

Associated to medical care, is the need for regular and appropriate exercises. At the Ladies Christian this is organised and executed by the occupational therapist, three times a month for the more mobile, and once a month for those in frail care. Moreover, residents should be encouraged to walk the long passages of the Home (all provided with handrails) for the purpose of exercising themselves and improving their walking ability.

Recreation is an important aspect of the function of institutionalisation. Accordingly, appropriate games are played at defined intervals; residents engage in various activities such as chocolate-making and card-decoration. Bingo is an attractive and popular past time. The end result of this recreation is not necessarily important; what is important is the obviating of boredom.

Entertainment plays an important role. Not so much entertainment generated by resident participation but entertainment provided by service organisation such as the Lions and Rotary Clubs. Moreover, various charitable organisations, schools and individuals provide varied entertainment which is invariably much appreciated.

Just as the non-institutional situation makes provision for the spiritual care of the public, the function of institutionalisation, likewise, provides spiritual care and succour for the residents. There is available to residents a public Bible study, a time of public worship and communion, and the availability of persons who are prepared to share in private prayer with residents.

Exposure to the media is an important function of institutionalisation. Newspapers are available in the lounges, there are two TV sets in public places, many residents possess their own TV sets and radios in their rooms, and other contemporary literature is distributed to certain residents.

The Home has its own library but the principal library activities operate through a weekly library service offered by the local authority who also provide a qualified librarian to assist the residents, many of whom are avid readers.

Commercial activity is also a key aspect of the function of institutionalism. Once a week transport is offered to the residents who are physically and mentally able to cope, to a shopping centre in the vicinity, where they do a certain amount of shopping, as well as minor banking transactions. Related to these commercial activities are two related activities, namely, the demand on the administration to give small change as well as to attend to a variety of postal matters.

The function of institutionalisation has been dealt with in some detail and covering a wide ambit. Certain other aspects can be mentioned briefly. One is the role of the administration to offer its advice on all manner of problems that arise from time to time. A second is the role of the administration in dealing with and advising on all

problems and difficulties relating to the payment of pension. A third, which has arisen in the past, and in all probability will arise in the future relates to manifold problems arising out of the casting of votes. In this regard the administration played a very active role. The last matter which is mentioned in regard to the function of institutionalisation relates to the conveyance of residents in the vehicles belonging to the Home. This may be private transport in the small car, or more public transport, in the microbus.

7.4 THE PURPOSE OF INSTITUTIONALISATION

The purpose of institutionalisation is dealt with in the Constitution², it is set out in the historical record³, and it manifests itself in the operation of the Home⁴. Each of these aspects have been adverted to in some detail as this thesis has progressed and it is not proposed to repeat the references, save in one respect. That respect eloquently sums up the purpose of institutionalisation, namely, “in all its endeavours it is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares”⁵.

If one is to reduce the purpose of institutionalisation to a short, single phrase, then it may be said that “it is to improve the quality of life of the elderly”. It goes without saying that the ambit of such a purpose is very wide. It is impossible to enumerate all its facets. Certain general characteristics will be mentioned.

Security is the watchword. This, in itself, covers a multitude of concerns. By definition (which is incorporated into the Constitution)⁶ this means ‘freedom from danger, care, or fear; feeling or condition of being safe’⁷. All people desire this; not

² *The Ladies Christian Home Constitution paras. 2 and 3*

³ *The Story of the Ladies Christian Home (supra) p 2*

⁴ *See Chapter Four : The Institution : Its Social Function*

⁵ *The Ladies Christian Home Constitution para 2*

⁶ *The Ladies Christian Home Constitution para 2*

⁷ *The World Book Dictionary*

the least of whom, are the elderly. With the advancement of the years comes a feeling of insecurity concerning deteriorating health, increasing forgetfulness, decreasing mobility, lack of financial resources, inability to cope with the ordinary demands of life, incontinence and so on.

Not the least of these feelings of insecurity relate to the continuance of the institution itself. Many reports have appeared and many rumours have been circulated, the result of which are feelings of insecurity and concern. A recent newspaper headline read as follows: "Golden dream fades for aged : City old age home may have to close as state subsidies shrink" ⁸. These feelings cannot be allowed to simmer; more importantly, they cannot be allowed to be converted into brooding panic. Security must be at the forefront of any and all messages which the institute may seek to proclaim.

Just as insecurity must be countered by assurance, so worry must be alleviated by composure. Worry is a universal emotion but some can cope with it more readily than others, especially if there are those to whom they can resort and share the worrying factor. The aged cannot, and do not, escape from worry. Like everyone else they worry about all manner of things. In some cases they are overcome by worries which, objectively handled, can very easily be resolved. But to whom do they turn, or with whom do they share their worries? The purpose of institutionalisation is to assuage the resident who is faced with a worrying factor, or perhaps, many worrying factors.

The mere fact of institutionalisation does not render void the emotional needs of a resident. While physical and mental needs are often detectable and therefore (sometimes) treatable, emotional needs are both harder to detect and to treat.

Often, what is needed is time, and opportunity, and a listening ear. This implies confidentiality, unhurried commitment, and an ability to react sympathetically but at the same time objectively and reasonably. But the purpose of institutionalisation is to be alive and sensitive to a variety of emotional needs.

⁸ See *Cape Argus* of 28th October 1999 (See Annexure C 1 hereto)

Not the least of critical matters with which a resident must deal is the question of what happens next. Not all institutions have frail care wings. The Ladies Christian Home not only has a comprehensive frail care wing but also an intermediate situation, where residents, who are not yet ready for admission to the frail care wing, can be moved and where they can receive more intensive nursing. Many of the aged fear 'another move' i.e. a move to some other place in some other locality, and find reassurance in the fact that if their situation deteriorates, there is a place to go where they will be well-cared for.

What then? Death is not a subject readily discussed, especially when life is expected to continue for some time. But what of the elderly? The average age at the Ladies Christian Home is just over eighty-six⁹; many are in their nineties, and one resident is over one hundred. How long does life go on? Some are tired and want to die, others are less willing to face the prospect. How does one deal with the problem? To say the least, opportunity must be given to those who want to discuss the matter, to discuss it. This discussion may be of a religious or spiritual nature, and if the services of a priest or minister are required, then such should be available, and timeously so. But it may not be. Who then deals with the matter? This is the purpose of institutionalisation.

What then? The response may be that there is not much more that can be done for or with a resident after death. But this is not so. There are those who wish to know (indeed, they ask about it) what will happen to their mortal remains after death. The purpose of institutionalisation is to deal with these problems by making provision for compulsory funeral policies, and the arrangement of a memorial service. It must be added that there are some (very few) who expressly state that they do not wish to be remembered by way of a memorial service.

⁹ *Calculated in November 1999*

While on the matter of death, there are related problems that arise, and these invariably relate to the matter of wills. This is a problematic issue which needs to be handled with sensitivity and skill. It can have far-reaching and unpleasant repercussions if handled by an unskillful or unscrupulous person. The obvious answer is to engage the services of a reputable attorney. But this costs money, which few can afford and relate to estates, which in most cases, are relatively small. But as death draws nearer the matter of succession (albeit in regard to a small estate) looms large. The purpose of institutionalisation is to deal with such matters as, to a lesser or greater degree, it has bearing on the quality of life of the elderly.

The purpose of institutionalisation does not easily admit of a conclusion. It is, however, proposed to bring the investigation to an end with one final observation. By and large, the majority of residents are not possessed with abundant finances, but they do sometimes encounter problems with such as they have. The purpose of institutionalisation is to alleviate these problems. This does not mean a 'handing out of money' or the negotiation of loans. It means assisting the resident with problems they may encounter in regard to money they possess i.e. problems with banking, making investments, and so on.

7.5 CONCLUSION

The institution has been looked-at from a number of points of view, as also the process of institutionalisation. The investigation now leads logically to an analysis and an assessment of the various situations relating to the resident, for this, ultimately, is the area at which the process of 'specialised visitation' is directed. The starting point is 'the resident: the nature and effect of the ageing process' which is the matter raised in Chapter 8 of Section D. In Chapter 9, the pre-institutionalisation position is dealt with at some length, while in Chapters 10 and 11 the process of institutionalisation is looked at from the point of view of its nature and effect, on the one hand, and the reasons and causes therefore, on the other. In Chapter 12, to conclude the section, the difficult, and oft neglected, subject of counselling receives considerable attention.

SECTION D. THE RESIDENT

Chapter 8. THE NATURE AND EFFECT OF THE AGEING PROCESS

8.1 INTRODUCTION

The resident plays a pivotal role in the process of institutionalisation, and therefore a pivotal role in the process of 'specialised visitation', and the function of the 'specialised visitor'. 'Specialised visitation' cannot be rightly understood and appreciated without a thorough investigation into the position occupied, and role played, by the resident. In the final analysis it is the resident who is visited, and it is the quality of life of the resident which may, or may not, be improved and enhanced by the process of 'specialised visitation'. Accordingly, the investigation proceeds by an intimate examination into the facts and circumstances surrounding the resident.

Before proceeding with an assessment of the nature of the ageing process and thereafter with the effects thereof, it is needful to address a number of fairly obvious observations of a general nature. The first is that, during the course of the investigation, the researcher was made painfully mindful of aspects of the distressing effects of the ageing process. The second is that it was obviously not possible, during the course of the investigation, to come to terms with the process of ageing in its entirety. At the same time, and this is the third of the general observations, the process of ageing is well-documented and can easily be ascertained by reference to text books¹, encyclopaedias² and academic works³.

It is against this background that the nature of the ageing process is examined and subsequently, the effects of the ageing process.

¹ See Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age* (supra) at p 91; Neil J. Smelser: *Sociology* 5th ed. Prentice Hall Inc. (1995) at p 248

² *The World Book Encyclopaedia* Vol.1 p 131; *New Illustrated Medical and Health Encyclopaedia* vol.1 at p98 and Vol.15 at pp 2021-2023

³ Anneliese Pierskalla: *The Implementation and Evaluation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged* (Faculty of Arts at the University of Port Elizabeth) 1994 at p18

8.2 THE NATURE OF THE AGEING PROCESS

The process of ageing, or growing old, is known as senescence. As people grow older, their bodies are subject to physiological degeneration. The cells of the body begin to lose their power of repair, and the glands tend to function less efficiently. Digestion becomes disturbed, and the senses of taste, smell, sight, and hearing often weaken or begin to fail. For example, the eyes lose their ability to adapt to darkness, and they require brighter light for reading. The lens of the eye cannot adjust so well as before to near and distant vision. A person also loses the ability to hear sounds of high frequency. About half the taste buds may be lost, and the capacity to detect odours decreases greatly.

In the ageing process of the human body, the condition of the blood vessels is the most significant single factor. Hardening of the arteries, the wearing out of the muscular tissues of the blood vessels, and heart failure are the result of degenerative changes in the tissues. As a consequence of these changes, the body may either lose bulk or become corpulent. The bones are harder and more brittle, the hair greys and often falls out, the capacity for muscular and frequent mental effort decreases, affecting the circulatory system, heart, kidneys, lungs and other organs begin to manifest themselves.

Many of the changes in the vision of older persons are due to changes in circulation, including hardening of the arteries. Sometimes a cataract, typical of old age, forms. The exact cause is not known, and the decision whether or not to remove a cataract depends on many factors related to the person's mental and physical condition, as well as the actual condition of the eye.

The eyelids of an older person develop wrinkles, and she seems to cry more easily, sometimes suffering from an excess of tears. This is often due to relaxation of the tissues of the eye, which do not hold the material as well as do the tissues of younger persons.

Like the rest of the body, the teeth and the jaws are subject to change in old age. The jaws change shape and the teeth tend either to fall out or require extraction. Artificial dentures often replace the loss of teeth.

The functioning of the digestive system becomes less efficient as a person grows older, and frequently a simpler, more easily digested diet is preferred. Three meals a day should still be eaten, but they can be smaller.

Although aches and pains may multiply as one grows older, there are no diseases specifically caused by old age, and many maladies to which older persons are subject result from chronic diseases which occurred years before. Afflictions among the elderly are many and varied, the most common including arthritis, rheumatism, hardening of the arteries, high blood pressure, and nervous and mental disorders.

Two matters need to be noted : one is that 'old age' cannot be defined exactly because the ageing process differs among individuals. A person of advanced age may have a healthier body and a more active mind than a much younger person. Conversely, a person who may be regarded as relatively young can have a diseased body and an affected mind. Secondly, older persons are coming to constitute an increasingly larger percentage of the population, and their particular problems are becoming of concern to more and more people.

Thus far, the comment has been limited largely to the physical state of the elderly. What of her mental condition? The mind of the senile person becomes feeble and she may be so confused that she requires constant care and attention, and cannot be left alone. This condition is also marked by extreme forgetfulness i.e. starting to do something and then forgetting what she started out to do, or walking about in a confused state, without having the presence of mind to ask directions.

Often the rest cycle is reversed, and the person sleeps during the day instead of at night. At night she is restless and sleepless. At daybreak, drowsiness sets in and she sleeps and dozes during the day.

As the situation deteriorates, coherent communication with others becomes difficult, even impossible and helplessness, incontinence, and loss of brain function may be noted. Often, old people, less affected, do not observe as acutely as do the young. They do not remember recent events. Eventually the loss of tissue from the ageing brain may reveal itself in apathy, irritability or stolidity. On the other hand, many old people talk and talk. This garrulousness may be accompanied by too great a concern over little, unimportant things and less concern about essential problems.

For old people, whether affected physically or mentally, movement becomes more difficult with age. By the age of eighty, about half the muscle cells have been replaced by other kinds of tissue. In women, especially, the bones lose calcium and become more likely to break ⁴.

8.3 THE EFFECTS OF THE AGEING PROCESS

The effects of the ageing process have been observed and noted over a period time. Moreover, the results have emerged from a number of different residents. One resident may reveal one symptom, while another may reveal another; moreover, a third resident may reflect more than one symptom. For the sake of convenience, the various effects are dealt with under the following headings : Physical; Memory; and Personal or Emotional.

8.3.1 Physical

The loss of hearing, in some cases, is only partial and communication, albeit with difficulty, is possible; in other cases, it is advanced and communication

⁴ See : *The World Book Encyclopaedia Vol. 1* p 131; *New Illustrated Medical and Health Encyclopedia Vol.1* p 98 and *Vol 15* pp 2021 - 2023

is possible only with the greatest difficulty. It gives rise to a number of problems. Not the least of these problems relates to the resident herself who, depending upon the degree of her deafness, is compelled to live in a world of silence. This is not of her choosing but because of her condition. If her deafness is of an advanced degree, she chooses the easiest of her options, and elects not to communicate. This is not necessarily a satisfactory answer but it does give rise to further problems. How does the 'specialised visitor' communicate? He develops a process, acceptable to the resident, whereby the silence is broken and a means of communication is slowly and effectively built-up. But there are still further problems, especially with those who have partial hearing. When they want to communicate, they cannot do so privately. They must shout, often to the annoyance and aggravation of other residents. Or if they partake in a public activity, they cannot hear what others can hear, and this leads to repeated questions; again to the annoyance of other participants. The loss of hearing, in its various manifestations, cannot be dismissed; it must be tackled not only to the benefit of the deaf resident but also to the benefit of the other residents who are not similarly afflicted.

Deterioration, and eventual loss of eyesight can similarly give rise to problems. The researcher was puzzled at a resident who persistently ignored him, until he realised that while she was visible to him, and he could greet her, she was to all intents and purposes blind, and was afflicted by a degree of loss of hearing. At the same time, she was a person who wanted to communicate. And so the problem was resolved. The greeting was tendered in a voice that could be heard, and a warm response was forthcoming. Moreover, a genuine relationship has developed to the obvious pleasure of the resident. This instance, has occurred in relation to more than one resident.

The question of cataracts presents a multi-faceted problem. Firstly, there is the physical problem of the resident who has been informed, medically, of her condition. Second, there is the problem of arrangements relating to the eventual hospitalisation. This is a traumatic and time-consuming ordeal which eventually leads to an arrangement that an operation will be performed on a particular day. Third, there is the emotional problem which the resident must endure pending the operation. This is often exacerbated by a postponement at the last moment of the operation. This, it may be said, applies not only to cataracts but to many aspects of medical treatment. It may be excused for numerous reasons, but it calls for sympathetic and sensitive treatment by the 'specialised visitor' who is called upon to explain and to deal with the problem.

Arthritis is said to be an inflammation of the joints of the body. The term, apparently, refers to all conditions that cause stiffness, soreness, or pain in the joints. Osteoarthritis, which is a form of chronic arthritis is said to exist in most persons over fifty years old "in some degree". Moreover, it is among the oldest diseases known to affect human beings⁵. The disease is progressive, involving many joints. It causes much swelling and pain. Eventually, the joints stiffen in deformed positions, producing crippling. If this was an exercise in conditions and cures of arthritis, the matter may be pursued. It is an exercise on the 'effects of the ageing process'. The effects of the ageing process, on a wide front, is arthritis in its various forms. Although there seems to be no authority to support the proposition, it is a condition which is affected by cold or windy weather, according to the many residents who suffer from the ailment. One, who is crippled and in a wheelchair, clings to the hope offered to her by the physiotherapist who treats her from time to time, and the 'specialised visitor' who regularly shares with her in her painful and deteriorating state.

⁵ *The World Book Encyclopaedia Vol. 1 p 716; The New Illustrated Medical and Health Encyclopaedia Vol. 2 p 239*

Osteoporosis is a disease in which the bone spaces become enlarged and the bones become weak and brittle. It occurs especially among old people, causing the bones to break easily and heal slowly. This is particularly worrying as many of the residents manifest severe bodily frailty and this, linked to a loss of balance and a tendency to fall, can cause life-threatening occurrences.

Observations have already been made concerning the rest cycle. Tiredness frequently manifests itself, not only as an expression of a physical condition, but as evinced by the fact that residents are frequently found to be sleeping during the day. But tiredness also reveals itself in another, and completely different context. Some residents have lived long enough and truly harbour a desire to die. This is a condition that has to be addressed, and a sympathetic response is demanded. Moreover, it may be associated with prolonged and unrelieved bodily pain which gives to the resident no comfort other than that which can be offered by a 'specialised visitor'.

Swollen ankles and sore feet give rise to recurring distress. A swollen ankle may occur in many conditions, especially kidney disease, heart disease, and in overweight persons, because of impaired circulation. Moreover, many persons, women especially, develop swollen ankles in hot weather. The feet are subject to a wide variety of disorders, such as fallen arches, ingrown toenails, corns, bunions, calluses, warts and chilblains. Furthermore, the feet may be subject to circulatory disturbances. The situation may be seriously aggravated by neglect or improper treatment and the services of a podiatrist should be available.

Not the least, nor the most pleasant, of the physical effects of the ageing process, is that of incontinence. It is a condition in which urine leaks from the bladder because of sagging of the urethra. This is an embarrassing and distressing problem, and one that requires sensitive and continuous treatment

on the part of the nursing staff. This relates not only to the personal hygiene of the resident, but also to the condition of the Home, as it can give rise to unpleasant and offensive odours.

Diseases of the heart and blood vessels can give rise to extraordinary problems, and frequently, give rise to the death of a resident. There are various kinds of heart disease, not the least of which is a hardening of the arteries which reduces the heart's blood supply, so may (and does) cause a pain in the chest known as *angina pectoris*. A second kind, and one frequently encountered, is *hypertension*, or high blood pressure. This is caused by an increased resistance to the flow of blood. The increased resistance occurs as a result of prolonged narrowing of the smallest arteries. As a result, the heart has to beat harder to pump the blood through the body.

8.3.2 Memory

Memory is the capacity to retain and revive impressions, to recall or recognise previous experience. It would seem that every experience and impression is permanently recorded in some way in the brain. However, intervening events and thoughts "block" or cover the vast majority of impressions, which, from a practical point of view, are forgotten⁶. Hardening of the arteries and diminished circulation of the blood associated with old age also have an influence on the memory⁷.

Memory problems are frequently detected among the residents of the Home. Moreover, they appear to worsen with time, often to the great distress of family who observe the changes from time to time. Language, with which the resident was previously fluent, begins to give rise to problems. Difficulty in naming objects becomes apparent; as does finding the right word to use in a

⁶ *The New Illustrated Medical and Health Encyclopaedia Vol 11 p 1532*

⁷ *The New Illustrated Medical and Health Encyclopaedia (supra) p 1533*

sentence. As time goes by it comes to the point where the resident starts speaking nonsense. But other effects also manifest themselves. They find it hard to dress themselves, and may not care about how they look; indeed they often resort to strange behaviour like wearing underclothes over topclothes or even taking off their clothes in public. They become careless about their hygiene and may not want to take a bath.

Depending upon the degree of the condition, they may manifest extreme mood swings, and change in mood for no reason. One moment they might be quite calm; then suddenly they become scared or angry or aggressive. The condition goes so far that even recognition of their own family and friends becomes difficult. At times, memories of childhood can be recalled, but nothing that happened in the recent past. They become suspicious of other people and very often may accuse them of stealing or hiding things.

They get lost in familiar places and cannot find their own rooms, the bathroom or the dining room. At night they may find the toilet, but be incapable of relocating their own rooms. This leads them to enter somebody else's room, wake that resident up and cause a disturbance.

What starts off as no more than a measure of excusable forgetfulness can end up as a resident becoming a victim of Alzheimer's Disease, which in its advance stage, renders the resident totally incapable of looking after herself.

8.3.3 Personal or emotional

In some residents there resides a desire to be noticed and they respond demurely to favourable comment. They may relate to an attractive outfit or a hair-do. The comment is appreciated and the reaction is rewarding. On analysis it would seem that favourable comment is not easily forthcoming, and when it does come it is greatly valued. On the contrary (as has been

observed), there is often manifested a lack of desire or commitment to look nice and attractive; indeed, the matter goes so far that it takes some effort to persuade the resident to change their clothes.

There are times of emotional upsets, coupled with unexplained weeping. With time and effort, a reason may be ascertained. This invariably relates to the resident's state and condition; the hopelessness of continuing with life; and the reduced quality or standard of life. Fortunately, it does not necessarily last long but it does require time, and effort, and interest to improve the situation and revive hope and bring encouragement.

At times it is difficult to elicit discussion; at other times comment is forthcoming. This may manifest a concern, even a worry, over a family member, or the family generally. More often than not, no interest is expressed concerning the family, or any member of the family. The discussion leads to a basic loneliness and a pre-occupation with a personal problem or a personal situation. This is all the more so where there is either an inability to read, or a lack of desire to read. Contrariwise, avid readers are often totally absorbed in their reading matter, though this is not a substitute for personal problems or difficulties. Many have been the occasions when a resident has abandoned a book for the purpose of sharing a personal problem or difficulty.

8.4 CONCLUSION

It has been observed that the nature and effects of the ageing process covers a wide area. When they are stripped of all the detail, what is left is an elderly lady in an institution; an elderly lady who is a person, stripped to some degree of her physical or mental abilities but left with her emotional and personal needs; needs which, if ignored, leave that resident unfulfilled and lacking in a vital aspect of her life and experience. There must be a ministry, a service to meet this need, if the quality of

life is to be improved and enhanced. The question that must be answered is : Who must minister? Who must render the service? Does it lie in the role and function of the 'specialised visitor'?

The nature and effect of the ageing process in relation to a resident cannot be viewed against the background of the institution alone and the process has proceeded against various backgrounds, not the least of which is the pre-institutionalisation position. According, it is to this subject that attention is now directed.

Chapter 9. THE PRE-INSTITUTIONALISATION POSITION

9.1 INTRODUCTION

The investigation of the resident cannot be confined to the post-institutionalisation position, as important as this position may be. Consideration must also be given to the pre-institutionalisation position, as this often gives rise to far-reaching repercussions arising out of the process of institutionalisation. It is a matter to which the 'specialised visitor' must give his attention, as he will be called-upon to deal with it, especially during the period immediately after institutionalisation has occurred. It gives rise to emotional outbursts, nostalgic recall, and a determination to leave the institution. More often than not, these emotional reactions are founded in fantasy, rather than reality. Nonetheless, it presents itself as a problem to which attention must be given, sometimes for considerable periods of time after institutionalisation.

9.2 COMPOSITION AND CONTENT OF FORMER HOME

The place in which the resident previously resided varies, obviously, from resident to resident. It may comprise a three-bedroomed home, with a sewing-room, garage and garden. In other cases, it is no more than a small flat. In yet other cases, it could comprise a unit in a retirement village, which (it is suggested) has proved unsuitable in the long term as it does not have a frail care wing. In whatever form it may have taken, it constituted a "home", that is, a place or dwelling where a person or family lives.

Moreover, the probabilities are that it is more than adequately stocked with furniture, fittings, decorations, appliances and equipment which have been accumulated over many years. To many of these items, while little or no great intrinsic value may be attached, there has grown and developed over the years, an enormous sentimental value. Often a resident may be inseparably connected to an

item, or a great number of items, which is little more than valueless rubbish. Valueless, that is to say, to all except the resident. Indeed, the family have often to endure the most scurrilous allegations that they deprived the resident of her 'most precious possessions'. This must not be dismissed as meaningless verbiage. It reflects a state of mind and an accumulation of emotions that take time and effort to clear.

Then there is the garden. The garden must be looked at from two points of view. The first is as a place; it is the place where the first-born child took his first steps; it is the place where the children 'rough-and-tumbled' with the new puppy; and it was the place where the first cricket games were played. It is a place full of memories and nostalgia. Secondly, it is a treasure-store of hard work and rich rewards. There, gardens were planted, flowers were picked, and lawns were mowed. Moreover, this was often a joint-effort with a partner long gone. It brings back memories, not just of a place, but of a person who meant very much to the resident over very many years.

9.3 IMMEDIATE FAMILY

The pre-institutionalisation position did not merely consist in a house, and furniture, and a garden; it was much more. It was a home. There the family was born and grew up. From there the children went to school. Home was the starting point of family holidays. Home was the place of achievement and disappointment, laughter and tears; failure and success. From home courtships developed, which led to marriage, and eventually the arrival of grandchildren.

Home was where friends were received; tea was drunk, and cards were played. In the home the matter of retirement arose, and with the passage of time, became the place of retirement. Home was where the golden and diamond wedding anniversaries were celebrated. Home was where the first spouse died; it became the house of sorrow, the house of loneliness. The home was the place where the remaining spouse first came to terms with the fact of advancing age; the first traces of a fading memory, and the first signs of bodily frailty.

It was at home that the first suggestions of institutionalisation were made, at first in more euphemistic terms, but eventually in strong and direct language. It was from the home, and accompanied by members of the family, that various old-age homes were visited, examined and debated. It was in the home, and with the family, that the final decision was made, that the home was chosen, and the 'wind down' operation commenced.

It was in the home and among the family that decisions were taken as to what should be kept, what should be sold, and what should be divided among the family. As helpful and co-operative as may have been the family, it was not they who were being institutionalised, but the resident. It was not they who were walking out of home, forsaking possessions, and turning their backs on a lifetime of memories, but the resident.

Moreover, the family itself had families. They had their own commitments and obligations. Each member of each family pledged their allegiance and continued interest, but each was busy, busier than the resident ever had been. Nonetheless, it was the family who bade the resident farewell, and it was the family who saw her safely and comfortably installed. It was the family who closed the door. Institutionalised.

Institutionalisation, as conceived and motivated by the family, must, for the purposes of the investigation, be accepted to be in the best interests of the resident. But it is the resident who is left with lingering and lasting memories; it is the resident who must adjust to a new milieu; and it is the resident who must start life all over again – as an elderly person.

9.4 INDEPENDENCE AND FREEDOM

The pre-institutionalised position is characterised by independence and freedom. Restraints which to a lesser or greater degree must exist, are largely self-imposed,

and self-regulated, especially when the age of retirement has been reached. The time to rise is not governed by an alarm; nor is breakfast determined by a chime of a clock, or the ring of a bell. Likewise, the time for lunch or dinner. Indeed, the very fact of lunch or dinner is a matter of election; an election whether or not to have lunch or dinner at all, or whether to have lunch or dinner at some place other than home.

There is no regimentation as to what will be done during the day or the evening. A day may be planned, or it may be allowed to develop as the hours pass by. Whether to shop or not to shop is a matter of choice; whether to play bowls or not, is determined only by the regulations of the club; whether to attend a cinema or not, is determined only by the choice of films; whether to play rummy or scrabble is determined largely (it is suggested) by what is being screened on television.

Life circulates around, either a couple (if both spouses are alive) or an individual (if there is no spouse, or the spouse is dead) and the couple (or the individual) do precisely as they please. There is no imposed restraint or control, there is no authority to whom they are answerable, and no set of rules by which they must govern their lives. They are not a small part of a large whole, always having to have regard to vagaries of others.

9.5 OPERATION OF HOME AND PERSONAL LIFE

Closely associated to the concepts of independence and freedom are the concepts of the operation of the home and the exercise of the personal lives of the occupants.

Sir Edward Coke said, "Every man's house is his castle".¹ Subject to the constraints imposed by law, every owner can operate his home as he chooses. He paints it when it pleases him, he modifies it as it suits him, and he occupies it in such a manner as he elects. He admits those who are his friends and family, and closes the door on

¹ *The World Book Dictionary Vol. One p. 320*

those who offend, irritate or anger him. He knows no limits or constraints, he acknowledges the mastery of no other, and he operates his home according to his own contentment.

He swims in his pool and he works in his garden; he plants what he likes and he picks what he likes; he works the soil, he weeds and he cuts lawn in accordance with his own whims and fancies. Any programme or pattern which dominates his actions are those devised by himself and to which he elects to submit himself.

He eats what he likes and when he likes, and he is answerable to no one in regard to the pattern by which he conducts his personal life. He wears what he likes when he likes and no one can compel him to adopt another mode of dress.

The pre-institutionalisation position is such that in the operation of his home and the conduct of his personal life, it is only the wishes and desires of the persons that count; the wishes and desires of others, however valid, need not be taken into account. They are irrelevant and create no binding obligation.

9.6 FINANCIAL CIRCUMSTANCES

Obviously the financial circumstances of a person can impose restraints and constraints on the manner in which he conducts his life. In this sense, it is clearly a limiting factor. If he has much he can expend much; if he has little he can only expend little. But the manner in which he expends his finances, whether much or little, he is the master of his own fate. If he under-expends, he ends up with a surplus, if he over-expends, he will find himself in financial straits. But nobody, save himself, controls his financial circumstances.

The pensioner must be more careful in the control of his financial circumstances than someone better endowed. The principle, however, remains the same. He is unrestrained and uncontrolled in the management of his financial circumstances.

9.7 LOCALITY AND SOCIAL CONTACT

Where a person lives, and moves, and has his being, in the pre-institutionalisation position, is his own business. To a certain extent he is limited and confined, namely, by his financial ability to reside in a particular area. However, within the confines of his financial circumstances, he is free to live where he pleases, or go where he wishes. He is not confined to a particular area, and he is not limited in his social contact.

Just as the pre-institutionalisation position does not limit or control a person's ability to live where he pleases and go where he pleases, so it does not limit or control that person's social contact. He may meet with whom he pleases, he may socialise with whom he pleases, and he may admit to his home whomsoever he pleases. No person can force or compel any other person to admit him to his house, to engage in conversation with them, or to participate socially with him.

If he elects to isolate himself socially, he is free to do so, just as he is free to remain in one locality, if that locality is pleasing to him. He cannot be prevented from entering or leaving his home but he can prevent others from entering.

9.8 CIRCUMSTANCES AND SURROUNDINGS

In the pre-institutionalisation position, and again, subject to the constraints of the civil and criminal law, no person can be limited or confined in the circumstances in which he elects to place himself, or the surroundings he chooses for himself. For better or for worse, he makes and moulds his own condition or state of affairs. Likewise, his surroundings. He cannot be compelled to accept or adopt a particular pattern of circumstances or surroundings. Similarly he cannot be compelled to abandon or reject a particular pattern of circumstances or surroundings. He controls his own condition or state of affairs, however objectionable or abhorrent they may be to those round and about him. People may advise, admonish or counsel a person in relation to his circumstances or surroundings, but they cannot exert any form of compulsion to force him to change, vary or modify the circumstances in question or the surroundings which he has chosen.

9.9 FAMILY AND FRIENDS

The pre-institutional home was often the gathering place for the family. This was especially so on special occasions or over week-ends. The parents were accorded the position of patriarch and matriarch. Despite increasing frailty they occupied a central position, surrounded by children and grandchildren. On special occasions the pre-institutional home could be a hive of activity, with tea and cake being served and adulation being proffered to the parents. The central position and the hierarchical station occupied by the parent or parents cannot be overemphasised.

Not only did the family gravitate towards the pre-institutional home, but from there the parents visited the family. They were free to move or were collected and then met at the home of a member of the family where other family members were present. But the centralised position of honour remained the same.

The pre-institutional home was also a meeting place for friends; to 'pop-in', to drink tea, to play cards, or merely to visit. Here again, they fulfilled the role of host and hostess, the central features of the activity. With the passage of time, and regard being had to advancing age, these friends gradually became fewer and the gatherings less frequent. But the home was there, the people were there, the activity was there, and in it all the parents played a pivotal role.

9.10 SHOPPING AND MEALS

Shopping always plays an important role in the life of the housewife; sometimes, also in the life of her husband. The thought occurred as to what was the most important feature of the regular shopping expedition. Was it the functional role of shopping, or was it the social role of getting out and meeting people? The answer is unimportant. The fact of the matter is that one or both spouses prepared a shopping list, went to the shopping centre, bought the goods, and paid the price. It was an

activity motivated and executed in accordance with their own election and volition. The management of the entire operation was in their hands and their hands alone. They were not dependent on anybody and they pursued the course as they best saw fit.

Likewise the meals. Again this fell to the lot of the busy housewife; but sometimes also to the husband. What was important is that they were not bound by timetables or menus. Indeed, they were not even dictated to by the meals themselves; if they felt like eating, they ate. If they did not feel like eating, they refrained. The situation was in their hands completely. They did not require the permission of anybody to prepare the meals, nor were they bound by any imposed formulas.

9.11 DOMESTIC ASSISTANCE

Sometimes a domestic employee plays a role in the pre-institutionalisation position. It obviously depends upon the financial position of the persons concerned. Moreover, the more the age advanced, the greater was the need for domestic assistance. Without going into the details of the domestic assistant's function or role, the important observation to be made is that she fell under the management and control of the persons concerned. It was they who determined her hours of work, the nature and scope of her duties, and it was they who paid her wages.

The significance of this pre-institutionalisation position is that it places the residents in a position of authority. It was they to whom the domestic assistant owed allegiance, it was in favour of the residents that the domestic assistant discharged her duties, and it was they who, in the end, were either satisfied or dissatisfied with the duties being performed. It was they who voiced approval or otherwise.

9.12 RECREATION AND LEISURE

With the advancement of the years, the opportunity and ability to participate in active recreation and leisure decreases. It can reasonably certainly be said that

where the institutionalised resident recollects aspects of active recreation and leisure, such occurred some years before the institutionalisation process began.

Nonetheless, despite the advancement of the years, opportunities for forms of recreation and leisure do present themselves. It may be in the form of attending a concert or a cinema, or perhaps, being taken for a drive or outing. It may be in the form of an afternoon or evening playing cards. The various activities, and the detail thereof, are unimportant. What is important is the role played by the resident in relation to a particular form of recreation or leisure, and what opportunity is given to them to express themselves or manifest their personalities in the way they see fit.

The point at issue is, as far as the pre-institutionalisation position in relation to recreation and leisure is concerned, that (within the scope of their physical abilities) than can do whatever they elect to do, in whatever manner they elect to do it, and whensoever they choose to do it.

9.13 CHURCH ATTENDANCE AND SPIRITUAL CARE

The aspects of conduct related to the subjects under immediate consideration are not of general application, and must be read to apply to those persons to whom church attendance and spiritual care are matters of importance.

Moreover, in principle, there is a close correlation between time given to recreation and leisure, and the time given to church attendance and spiritual care.

Church attendance is a matter of personal preference or conviction. It may even be a case of habit. Likewise, spiritual care, especially where it takes the form of daily Bible reading and private prayer. The participation in the devotion of communion is acceptable (even compulsory) to some but not to others.

But whether or not it assumes a lesser or greater degree of significance, it is the resident (or residents, as the case may be) who exercises a choice or election. It is he, or she, who decides whether or not to participate in divine worship, or partake of holy communion, or call upon the minister or priest to exercise a pastoral ministry. There is no programme of religion and no compulsion to partake. The decision to attend church, or manifest the need for spiritual care in other forms, is essentially a private matter to be exercised in a private and personal way.

9.14 MEDICAL CARE AND HOSPITALISATION

The health care of a person depends, in first place, on his or her physical, mental or dental condition. In the second place, it depends upon the financial resources of a person; and in the third place, it depends upon whether the benefits of a medical aid scheme are available, and what the extent of those benefits are. The whole matter is a source of grave and growing concern, as medical costs rise, and medical benefits become more circumscribed. It is not intended to embark upon a general discussion on medical care and hospitalisation. What is proposed is to examine the pre-institutionalisation position in relation to these two matters.

Where the physical, mental or dental state posed no significant problem, the pre-institutionalised position presented no weighty role, other than that the person, when necessary, could have such recourse to medical care (or hospitalisation) as his or her financial position or medical aid scheme permitted. The choice was essentially a personal one with no restraints or controls, other than those referred to.

Where the position was otherwise, and one or both the persons suffered physically, mentally, or in any other manner, there was no medical aid available, and the finances were limited, the position was dramatically altered. Here, restraints and controls, played an important role and these will be dealt with in the next chapter.²

² See Chapter Ten : *The Resident : The Nature and Effect of the Process of Institutionalisation*

What needs to be noted here is the fact that where either finances or medical aid benefits were available in the pre-institutionalisation position, the choice of medical care or hospitalisation, lay with the person concerned, to be exercised in whatever way chosen, with no restraints or controls other than those arising out of the financial position of the person, or the regulations of the medical aid scheme.

9.15 TRANSPORT AND MOBILITY

The pre-institutionalisation position presupposes the physical and mental ability to drive or to use public transport (where it exists). Although it is dangerous to generalise, it may fairly be said that the older one gets the more dangerous it becomes to drive, and indeed, to use public transport.

Many an institutionalised person can, however, look back to a time when she either drove or used public transport, or, for that matter, walked to an attainable destination. It is an area where concessions are not readily made. As to whether a person is able still to drive or not, is often the subject of vigorous debate.

Likewise, as to whether a person is able to walk to a particular destination or not, often admits of lively discussion. These matters are not pursued. What is pursued is the pre-institutionalisation position.

This position is characterised by a mobility which related only to volition. If a person wanted to drive somewhere, she drove there; if she wanted to walk somewhere, she walked. Nobody controlled, or restrained, or limited the mobility. It is conceded that often times the person herself, because of a physical or mental condition, has admitted to constraint, restraint and limitation. But until then, or in the absence of such admission, the predominant factor was volition, or a free choice.

9.16 CHANGES IN CIRCUMSTANCES

Circumstances can change, and do change. These changes are manifold and each does not admit of comment. Certain of the more obvious changes are adverted to.

Not the least of these changes, is the sudden or lingering death of a partner. When a person is left alone, it can have far-reaching repercussions, sometimes involving quite radical financial restraints. Indeed, a reduced financial position can vitally alter a person's attitude to the pre-institutionalisation position. Then there is a decline in health linked to a reduced mobility and resultant inability to cope with the prevailing situation. These events lead naturally and directly to a reduced ability to look after and manage the property.

The advancement of the years has further ramifications. As one group of people are getting older, so are their contemporaries. They are moving off to other places; to live with their families or to be institutionalised. The other eventually also presents itself. Death of one's friends and associates, the very people who were their social contacts and confidantes. What may be termed 'the final straw' is the departure of members of the family to other places or to other countries.

The pre-institutionalisation position, which to a very large extent was localised in a 'house and a castle', and about which all the important events of life circulated, suddenly manifested itself as a place of vulnerability offering little by way of 'freedom from danger, care, or fear'.³ The quest that now presented itself was for a home or institution whose 'primary concern (was) for ladies who are elderly, infirm and needy'.⁴

³ *The Ladies Christian Home Constitution para. 2*

⁴ *The Ladies Christian Home Constitution para. 2*

9.17 MOVE TO ENTER A HOME

The argument that has been advanced that the pre-institutionalised position leads logically and naturally to institutionalisation. This may be the case but it is not necessarily so. Often the person concerned puts up spirited resistance to institutionalisation. Sometimes the family is the motivating factor; indeed, the only factor, with no co-operation or consent from the person concerned. Whatever are the influences, the end result is institutionalisation.

9.18 CONCLUSION

The pre-institutionalisation position has been presented as 'the hurdle to be overcome' in the process of institutionalisation. The resident must now be examined in the light of the 'nature and effect of the process of institutionalisation' and it is to this matter that attention is now directed.

Chapter 10. THE NATURE AND EFFECT OF THE PROCESS OF INSTITUTIONALISATION

10.1 INTRODUCTION

The process of institutionalisation has been examined in two different contexts. The first occurred against the background and within the specific context of the institution.¹ The second occurred against a more generalised background which was directed at an understanding of the process of institutionalisation.² The emphasis of this chapter is primarily upon the resident; to examine the resident against the background of institutionalisation, and to decide its nature in relation to the resident, and to determine the effect of the process on the resident.

However important may have been the previous chapters³, the central theme of the investigation is the resident, and ultimately whether the process of 'specialised visitation' can improve and enhance the quality of life of the resident. Accordingly, attention is now directed at the resident within the context of the nature and effect of the process of institutionalisation.

10.2 THE NATURE OF THE PROCESS OF INSTITUTIONALISATION

Conceptually, the process of institutionalisation may commence at an earlier stage⁴, but factually and crucially, it commences with a physical and emotional removal from the pre-institutionalisation position i.e. from the former home, whatever shape or form that erstwhile home may have taken.⁵ The significance of this moment and occurrence cannot be overemphasised. Former situations vary from person to person; for one it is a tiny flat, for others it is the family home that has been occupied for decades. There is the furniture and the contents, many of the pieces of which have special significance. Perhaps (it is suggested), more important than all things else, are the memories, the nostalgia, that haunts the resident as she closes the door, or takes a last look.

¹ See Chapter Six : *The Institution and the Process of Institutionalisation*

² See Chapter Seven : *The Nature, Function and Purpose of Institutionalisation*

³ i.e. Chapters Six and Seven

⁴ See Chapter Seven: *The Nature of Institutionalisation*

⁵ See Chapter Nine : *Composition and Content of Former Home*

For the social worker, the family, the friends, the memories and the nostalgia, are factors which are easily dismissed. But not so for the resident. For her these factors linger for a long time. Indeed, whatever physical weaknesses may be present, or whatever degree of forgetfulness may haunt the resident, these are constantly and repeatedly overlooked, and the longing to return to the erstwhile home remains. Often, the family are blamed for being cruel, unsympathetic and feelingless.

Removal from the home is one factor. A second is resettlement in the Home. Not a home, but a room in the Home. Often odd items of furniture are brought from home; these are precious but they are few. The room is invariably made to look nice, and every effort is made to make the resident welcome. But it remains a room and all the other facilities are shared with others; the bathrooms, the lounges, the alcoves, the dining room, and the toilets. Privacy is to be found in a room.

A third factor is the matter of control. Whereas the pre-institutionalised position was characterised by independence, freedom, and the exercise of a free will ⁶, the new position required the resident to submit herself to the rules of the Home. ⁷ It is not intended to suggest, or, in the remotest degree to insinuate, that the resident is being 'imprisoned' or being made the inmate of a penal institution. What is being suggested is that she is being incorporated, as an individual, into a larger whole. Accordingly, the first rule of the Home reads as follows:-

"The aim of the Board of Trustees, General Manager and Staff is to attempt, as far as possible to make the residents feel that they have a new home. It is the wish of the Board to create and maintain a pleasant atmosphere in the Home. For this reason it is expected of each resident to conduct herself in such a manner that life will be a pleasure to them and to others" ⁸

From the point of view of control, reference is made to the second rule:-

⁶ See Chapter Nine : The Resident : The Pre-institutionalised Position

⁷ See : Ladies Christian Home : Rules of the Home (Annexure B)

⁸ Rules of the Home (supra) Rule 1

*“The General Manager has complete authority and supervision over the home and acts on the instructions of the Board. The residents are expected to respect her as well as other members of the staff and not to interfere with their duties”*⁹

No more is intended to be said, other than that there is a significant shift of control from the pre-institutionalised position, to the institutionalised position. Without belabouring the point, no liquor and no smoking is allowed in the Home¹⁰, and no electric irons, hotplates and kettles are allowed in the rooms except by special permission of the General Manager.¹¹

It is not suggested that the rules¹² are other than in the best interests of the residents. What is suggested is that institutionalisation incorporates a shift in control.

Coupled to the concept of control is the concept of standardisation. It is not suggested that in the pre-institutionalisation position standardisation or conformity was absent. In all probability it existed but it was linked to an election, an expression of volition, to freedom and independence. For the resident, standardisation or conformity is an essential characteristic of the nature of institutionalisation. It manifests itself, and forms part of almost every aspect of daily life.

Meals are served at fixed times, with little provision for flexibility (though altered times are not impossible) and each mealtime is heralded by the sounding of the meal-gong. Baths are taken at fixed and determined times. By and large, the regular activities are at fixed times on fixed days; Monday is fixed for Bible study, Tuesday is fixed for divine worship; Wednesday brings with it the prospect of shopping by courtesy of free transport to and from the nearby shopping centre, and so on. Life circulates around a pattern which is published in advance on the notice board.

⁹ *Rules of the Home (supra) Rule 2*

¹⁰ *Rules of the Home (supra) Rule 15*

¹¹ *Rules of the Home (supra) Rule 18*

¹² *See : Rules of the Home annexed hereto (Annexure B)*

Special items of entertainment are arranged from time to time, and these likewise, are made known, and residents are encouraged to participate according to their physical and mental abilities.

Standardisation and conformity characterise other aspects of daily living. There is, for instance, a regular and accepted formula in regard to laundry, and any items of maintenance or mending. The residents know the procedure to be observed in regard to nursing assistance or the cleaning of their rooms.

The nature of the process of institutionalisation is distinguished by another characteristic, namely, that of contextualisation. It is not suggested that the resident loses her identity, or her personality, or becomes a mere number in a greater group of people. The whole emphasis and *ethos* of the home is directed at the importance of individual personality. At the same time, by the very nature of institutionalisation, the individual is incorporated into the larger body, and just as the resident is recognised and treated as an individual, so is the larger body recognised as a corporate group, treated as such, and administered as such.

Whereas the nature of the pre-institutionalised position is characterised by the importance of the individual and the satisfying of her wants, desires and needs, so the nature of the post-institutionalised position is characterised by the importance of the individual in relation to the operation of the corporate body as a whole.

Consequently, each and every individual aspect of the day-to-day experience of a person cannot be heeded, especially where it conflicts with the smooth operation of the whole. Sometimes the resident finds it difficult to yield to the greater good of the majority, and expects to be treated as though her wants and needs were the only factors to be considered.

In this regard mobility is an important factor. Special rules apply to short absences so that the administration should be aware of the resident's movements. Longer absences are governed by the Rules of the Home.¹³ Moreover, vacations are not a matter of choice, but are regulated to one month per year.¹⁴ On a more practical level, residents confined to a wheelchair require the assistance of a nursing aid. This can be a source of aggravation when a nursing aid is not immediately available. A strange observation by the researcher is that despite the fact that time is seldom an important factor, the resident invariably wants things done immediately; she does not want to wait, whether it be for attention, or for the elevator.

It is not easy for a resident to adopt the cherished attitude of 'minding her own business' especially in the sphere of finance, as one of the characteristics of the nature of the process of institutionalisation is to make public the matter of finance. The Rules of the Home provide that 'residents are obliged annually, or when requested to do so by the Board, to furnish documentary proof of their financial position'.¹⁵

As a matter of fact, in the majority of cases, the finances of the resident, especially those who in receipt of old age pensions, are governed and controlled by the administration. It is the administration who monitors the financial position of residents, even to the extent of their 'pocket money'.

The role and function of the administration has been dealt with at some length.¹⁶ Here, comment is limited to the interaction between the resident and the administration as reflecting upon the nature of the process of institutionalisation. The structure of the Home is wider than the administration.¹⁷ However, from the point of view of effective contact between the Home and the resident, this is done through the offices and personnel of the administration. Where limitation and

¹³ *Rules of the Home Rule 8*

¹⁴ *Rules of the Home (supra) Rule 9*

¹⁵ *Rules of the Home (supra) Rule 12*

¹⁶ *See Chapter Five : The Institution : its Administration*

¹⁷ *See Chapter Three : The Institution : its Social Structure and Chapter Five : The Institution : its Administration*

confinement are the principal characteristics for institutionalisation, there must be an out-let, an escape-valve, a point of action and authority where the resident can find comfort and strength. This is the administration. Many of the matters raised by residents must be dealt with by the administration in the exercise of their function.

But there are other matters. And the time and the availability of the administration are limited. The 'non-official' matters can often be dealt with by a 'specialised visitor'.

There are three other matters (possibly among many more) which characterise the nature of the process of institutionalisation, and to which reference must be made. Observation has been made of the pre-institutionalisation position.¹⁸ Although economic residents who possess the finances have a choice to attend a doctor of their selection, the indigent residents must content themselves with the services of the Home's doctor (a district surgeon), the Senior Sister or the nurses on duty. Where hospital services, or hospitalisation, is required, resort must be had to State hospitals. This is often a source of delays, aggravation and even exasperation. But there is no choice. This is part of the process of institutionalisation.

The second matter to which reference must be made is that of contact with people. Many residents (even indigent residents) have their own telephones and this is a vital and convenient means of contact with the outside world. Public telephones are available but these are not always a convenient means of communication. The administration has letter-cards and stamps available but these can be used only by those who can see and still write legibly. Few limits are placed on personal visitation during the day but for security reasons, not after 1900 hours. Here again, the obvious observation must be made: that one of the consequences of institutionalisation is limited and confined contact with people.

¹⁸ See Chapter Nine : Medical Care and Hospitalisation

The third and final matter which is characteristic of the nature of the process of institutionalisation relates to the activities in which the resident participates. Not surprisingly, the number of residents who partake of activities, outside of those offered by the Home, are few in number. The reasons for this are manifold. Some are physically handicapped; others are lacking in intellectual ability; there are those who do not possess the finances; some are just lethargic; some lack mobility. Moreover, as the passage of the years advances, the desire to partake in activities, decreases. But whatever the reason, the fact remains that, while there are exceptions, the general rule is that the trend with institutionalisation, is a decrease in the participation in external activities.

10.3 THE EFFECT OF THE PROCESS OF INSTITUTIONALISATION

People differ from person to person, in reaction to a new situation, in attitude, in emotional response. It is only to be expected that the effect of institutionalisation will vary from person to person with no fixed or determined pattern to be observed. Nonetheless, a variety of differing effects do emerge and to them attention is now directed.

One effect is that of acceptance of the institutionalised situation; not simply a resigned, passive, quiescent acceptance but a genuine, enthusiastic and excited acceptance. One may be tempted to relate this to an unfortunate pre-institutionalised position. But this is not necessarily the case. One resident was relocated from a most favourable pre-institutionalised position and one would have expected her to be disappointed and disillusioned at the institutionalised position. But this was not the case. Immediately she expressed a spirit of satisfaction and buoyancy which has persisted since her admission. This (and other situations) leads one to believe that acceptance (or rejection) is more a state of mind and of emotions, rather than the physical aspects of the new surroundings or the various elements that characterise institutionalisation.

A second effect is that of rejection of the institutionalised situation. The welcome given to the resident, the efforts made to make her feel at home, the physical surroundings, the services offered, a pleasant atmosphere, are all, singularly and collectively, of no avail. The new position is not only unacceptable, it is totally and absolutely rejected. Here the mind (and the heart) is fixed and immutable. Indeed, one resident had been in the Home for three years and her attitude remained the same. Regardless of her physical condition, she longs for her pre-institutionalised position.

Another effect is that of adjustment, not merely an acceptance of her new position but a total alteration of mind and attitude. This cannot be rejected as a totally unreasonable state of mind. A removal from one's home (with all that means) ¹⁹ and resettlement in an entirely new environment, is a move of major proportions and mixed emotions on the part of the resident must be expected. Adjustment is not easily achieved, but where it is achieved, it is to be lauded as a worthy alteration of a state of mind.

A fourth effect is not necessarily a lasting one, but one that manifests itself from time and depends upon surrounding circumstances. Aggravation. Situations frequently arise (not necessarily purposely) which cause a feeling of aggravation. The eating habits of a person at the same table. This may not be a simple case of manners; it may be that the person concerned has poor eyesight. Or the removal, at the meal table, of dentures. Once again it may be attributable to causes which are unintentional. But wherever a large group of people are living in close proximity, causes for aggravation must arise. In the end, wisdom and diplomacy must prevail, lest matters proceed out of all proportion.

A further effect is one of patient tolerance which often gives rise to lasting and meaningful friendships. Like-minded residents meet to play scrabble or just to enjoy a cup of tea. Some who are more physically able will perform acts of kindness for

¹⁹ See Chapter Nine : *The Resident : The pre-institutionalised position*

those who are less able, such as shopping. As in normal society, friendships can give rise to difficulties, such as where a popular resident pays too much attention to another resident and petty jealousies occur. But friendships do arise, perhaps, out of sharing the same table at mealtimes, or sharing a common interest on the same floor.

A sixth, and very prevalent effect, is that of solitude. Many residents prefer their own company, and the surroundings of their own rooms. Despite the provision of attractive and well-appointed places of meeting, such as lounges, and alcoves, residents are frequently found alone and in the solitude of their own rooms. Many are avid readers, and this may be an explanation; others are not readers but have defective hearing and therefore avoid company. Yet others are incapable of sustained conversation and therefore do not attract other residents. Some do not sleep at night, and compensate for lack of sleep, by sleeping during the day. There does not appear to be a single reason, and each resident thinks and speaks for herself, but many are the occasions that residents are found to be alone in their rooms.

By the very nature of institutionalisation, another effect is that of limitation in contact. Social contact, to a very large degree, is limited to the administration, the family, friends and the 'specialised visitor'. It has been stated on a number of occasions that the resident's contact with the administration is important as it carries with it authority and control. But by the very nature of the operation it is limited, but at the same time sympathetic and sensitive. Social contact with family and friends varies from resident to resident, both in regularity and depth. In some instances, social contact, particularly with the family is regular and meaningful. In other instances, the contact, if at all, is irregular and, in any event, is confrontational and filled with tension. As to who is to blame is debatable; it may be the family, it may be the resident. But distribution of blame is neither here nor there. The fact of the matter is that an opportunity for desirable social contact has not achieved the

intended purpose. Social contact with the 'specialised visitor' is regular and continuous. It varies in depth, depending on the state of mind (or heart) of the resident. It may be superficial; no more than the passing of the time of day, or it may be deep, if the resident is burdened with concern. But whether deep or not, the contact is regular and continuous, and relationships are built-up and strengthened.

Limited social contact is linked to limited freedom on the part of the resident. Independence and freedom are important aspects in the life of everybody;²⁰ no less those who are institutionalised. But by the very nature of institutionalisation, an element of control must be incorporated. Just as the personality of the individual must be recognised, what must also be recognised is that she is one of a much larger group. This very fact implies a measure of limitation of the individual's freedom. Not so much with sub-economic patients, but with economic patients, their finances are often controlled by the family and this leads to a great deal of dissatisfaction. They desire to exercise control over their own affairs.

Not surprisingly one effect of institutionalisation is the manifestation of an attitude or reaction towards the Home. This may be of permanent duration or it may evidence itself from time to time. It has been described as "the manifestation of an attitude or reaction towards the Home". On analysis it is more properly said to be an attitude or reaction towards an aspect of the social structure of the Home i.e. the doctor, the senior sister, the nurses, the kitchen staff or the cleaning staff. The resident may be full of praise for one or more of these aspects, or she may decry them. Something or someone may have upset or disturbed her and the Home, as an institution, becomes tarnished and condemned. On the other hand, someone may have done something particularly pleasing, or the meals may have been particularly good, and the Home becomes an agreeable and pleasing place. Some residents never change; the Home for them is a most acceptable place. Others change as circumstances change; the Home can be good, just as it can be bad. Yet others, also never change; they never asked to be in the Home, they don't want to be in the Home, and as far as they are concerned, the Home is a disaster.

²⁰ See Chapter 9 : *Independence and Freedom : also The Nature of the Process of Institutionalisation (supra)*

It is intended to mention one last factor as an effect of the process of institutionalisation. It relates to foresight, expectation or anticipation on the part of the resident. It is not suggested that residents are institutionalised for the purpose of dying. The fact is that many residents are very old and very infirm. Their vision for the future is, obviously, limited. Moreover, for many, death is nigh. Where the ability to think and to contemplate is still present, the thought-processes must be understood and where necessary, dealt with. Indeed, in Chapter Twelve, attention will be given to the matter of counselling the resident.

10.4 CONCLUSION

There is little doubt that the process of institutionalisation is far-reaching both in its nature and effects. It needs to be understood, and if needs be, expounded and unfolded. Counselling may well be the answer and this matter will receive attention.²¹ Before doing so, however, it is needful, briefly, to examine the resident in the light of the reasons and causes for her institutionalisation.

²¹ See : Chapter Twelve : *The Resident and the need for Counselling*

Chapter 11. THE REASONS AND CAUSES OF INSTITUTIONALISATION

11.1 INTRODUCTION

The resident is now looked at against the background of the reasons and causes of institutionalisation. The question that falls to be answered is : what gives rise to a person being institutionalised, or, more pertinently, why does a person live in an old age home? On a careful analysis, just as people vary from person to person, so the reasons and causes for institutionalisation will vary from person to person. Generally speaking, however, similarities can be detected and patterns emerge which indicate a norm or type into which the varying experiences of people can be made to fit, with allowances being made for various discrepancies as they emerge from person to person.

It is to these generalised patterns that attention will be directed as indicating the reasons or causes for institutionalisation. It is not suggested that the various categories are final and complete, but they will give a clear indication of the principal reasons or causes of institutionalisation.

11.2 REASONS OR CAUSES OF INSTITUTIONALISATION

Old age, in relation to institutionalisation, does not admit of definition, that is to say, a defined number of years.¹ In other words, admission to an old age home is not necessarily dependent upon the resident being a 'person of advanced age'. Indeed, one reason or cause of institutionalisation may be attributed to a 'pre-advanced age condition.'

¹ See Chapter Eight : *The Nature of the Ageing Process*; Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age (supra)* at p 79; Neil J Smelser: *Sociology (Fifth Edition) (supra)* at p 247; Anneliese Pierskalla: *The Implementation and Evaluation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged (supra)* at p 15

This applies to residents who are, relatively speaking, quite young. To give an indication, under the age of sixty years. All other things being equal, she, in all probability, would not have sought (indeed, would not have qualified for) institutionalisation. But all other things were not equal. Placing the matter at its highest level, the resident was of a low I.Q., or stated otherwise, was slightly retarded. She needed specialised care; not the care offered to persons who are mentally defective or deficient or retarded, but the care offered to those of an advanced age.

The purpose of referring to the specific incident is not to open a debate on the pros and cons of the treatment offered to the mentally retarded. It was simply an illustration of a 'pre-advanced age condition' for which 'old age' institutionalisation offered an answer to a problem. Lest it be thought that the characterisation was linked to a specific instance, this was not the case. Moreover, the emphasis must be placed on the care and treatment that can be offered by an institution such as the one under discussion.²

For want of improved terminology, the second reason or cause of institutionalisation is described as 'mere advanced age'. This is only a partial description in that it embodies more than 'mere advanced age'. 'Mere advanced age' relates to ladies who are of an advanced age (over ninety in some instances) but suffer no other maladies, such as chronic forgetfulness or physical malfunction. The inadequacy of the description lies in the fact that they were unable to cope with a pre-institutionalised position, and therefore sought institutionalisation. Many are immaculate of appearance and of stately physique. Of the various groups of ladies that inhabit the Home, these are the most difficult to which to minister, as they are strong of body and fine of mind. Conversation is required to be of the highest level, and problems must be dealt with specifically and intelligently.

² See : Chapter Four : *The Institution : Its Social Structure* and Chapter Five : *The Institution : Its Administration*

The ability to cope with the pre-institutionalised position, whether linked to advanced age or not, or whether linked to other factors (to which reference will be made) or not, is frequently a matter which gives rise to institutionalisation. The physical condition of the resident may be such that she is incapable of operating the pre-institutionalised home; she is unable to attend to the shopping and prepare meals; she can no longer drive the car and she becomes house-bound. With the passage of time she finds bathing difficult and needs assistance to get in and out of the bath. This invariably leads to carelessness in regard to personal hygiene, which is a matter more readily observed by members of the family or friends, than the resident herself.

In advancing the inability to cope with the pre-institutionalised position as a reason or cause for institutionalisation, a distinction is drawn between two physical situations. One is the physical inability to cope with the ordinary day-to-day activities of life. The other relates to the pre-institutionalised structure which constituted the resident's home i.e. an inability to cope with a building and its surroundings.

A comparable but different situation presents itself in what may be termed the 'advanced age syndrome'. Albeit not a syndrome which is easily recognised by the resident as a reason or cause for institutionalisation, it is the most familiar of all the reasons or causes leading to institutionalisation. One aspect of the syndrome which is, initially, sometimes difficult to detect is that of increasing forgetfulness. At first it is rationalised on the basis that forgetfulness is common to all, especially as age increases. But with the passage of time it reaches alarming and disturbing proportions. So much so that a mild form of mental defectiveness is diagnosed. Whether or not the diagnosis is scientific, or even accurate, is neither here nor there. What is unquestionable is the consequence. Institutionalisation.

Another manifestation of the 'advanced age syndrome' is some form of physical affliction, be it bodily frailty or failing sight or incontinence. It may be an affliction of a more serious nature such as a stroke, or reduced mobility, or falling. This invariably leads to the conclusion that the resident is incapable of looking after herself and therefore some form of institutionalisation is imperative.

There are other reasons or causes for institutionalisation to which reference will presently be made. The 'advanced age syndrome' leads logically, however, to another, and sometimes, unpopular reason or cause for institutionalisation, namely, family pressure, arising out of an inability on the part of the family to cope with the resident. Let it be said immediately, that while, in certain circumstances, sinister elements on the part of the family present themselves, in most cases, the family is motivated by the best interests of the resident, and approach institutionalisation prompted only by a loving and caring concern for the resident.

It has been suggested that the 'advanced age syndrome' is not easily recognised by the resident. The suggestion is repeated but not limited to the 'advanced age syndrome'. Indeed, in many of the situations which constitute reasons or causes for institutionalisation, the resident is slow to accept that she is anything other than perfectly capable of looking after herself in the circumstances with which she is familiar. Indeed, she is likely to dismiss with contempt, any move to 'put her in an old age home'. She may be even more vehement and accuse the family of 'putting her in an old age home' so that 'they (the family) can grab my money'.

Disregarding any sinister motives and evil intent, it is usually the family that are closest to the resident and more favourably placed to observe changes in conduct and patterns of behaviour which suggest the advancement of the years and an increasing lack of ability to cope with matters that were formerly commonplace. Moreover, if there has been a deterioration in the conduct of the resident so that institutionalisation is a prospect, it is the family who is the most logical unit to make investigations initially, and later, the necessary arrangements for institutionalisation.³

³ *The role played by the family in the institutionalisation process cannot be overemphasised and particular attention is given thereto in Chapters Thirteen, Fourteen and Fifteen.*

In dealing further with the reasons or causes of institutionalisation, terminology once again presents a problem. For the sake of convenience the terms 'chronic advanced age condition' is adduced as a reason or cause of institutionalisation. The terminology is best given meaning by referring to those who are suffering from chronic arthritis,⁴ and whose mobility is dependent upon being pushed in a wheelchair. To give them an enhanced quality of life is difficult enough in an institutionalised situation; it must have been hopeless in the pre-institutionalised position. Likewise, the senile person who requires constant care and attention, and cannot be left alone.⁵ The 'chronic advanced age syndrome' encompasses many afflictions which cannot be endured in the pre-institutionalised position. It opens the way to institutionalisation.

Before concluding this chapter, one last reason for institutionalisation must be considered. The advancing years bring with them many differing emotions, not the least of which, is fear; fear of the future, however long or short that may be. Many elderly people have lost their contemporaries, their spouses, their friends. Some have lost members of their families, either through death or through dispersion; some have very little left in life. Their minds wander, their bodies are racked with all manner of pain; for all intents and purposes, they are housebound. No one cares for them; to make a cup of tea or prepare a meal is a burdensome task; life itself holds out little by way of quality. Death may be imminent. Where then does the future lie?

Institutionalisation, for those who fit into this mould, provides an answer to their problem. It offers safety and security for the time that is left to them. Moreover, if life proves to be longer than anticipated, and with that life a progressive deterioration, there is a frail care who will care for them until life is done.

There are some who think and feel like this; for whom institutionalisation is not an incarceration but an enhanced and an improved quality of life.

⁴ See Chapter Eight : *The Effects of the Ageing Process*

⁵ See Chapter Eight : *The Nature of the Ageing Process*

11.3 CONCLUSION

It is probably true that for as many elderly people as there are, so many are the reasons and causes of institutionalisation. It is not possible to deal with them all.

But some recur and are common experiences to many of the elderly. These have been recorded as reasons and causes of institutionalisation. But institutionalisation is not the answer to all problems that arise; life must continue, and with life, there arise problems and difficulties. Who is there to turn to with these problems and difficulties? Is there a need for counselling, and if so, who will offer counsel? It is to this matter that attention is now directed : the resident and the need for counselling.

Chapter 12. THE NEED FOR COUNSELLING

12.1 INTRODUCTION

The resident has been examined in a number of different contexts, leading ultimately to the central aspect of visitation. The resident has been examined against the background of the ageing process;¹ her pre-institutionalisation position has been taken into account;² the nature and effect of the process of institutionalisation upon her has been analysed;³ and the reasons and causes of the institutionalisation of the resident have been scrutinised.⁴ The last aspect of the section is now investigated, namely, “The Resident and the Need for Counselling”.

A word of explanation is offered at the outset. The investigation is not an easy one. Different types of counselling are referred to, and at different periods of time. Moreover, the objective aimed at is the role and function of the ‘specialised visitor’. It is not suggested that the ‘specialised visitor’ is the answer to all the problems related to advanced age; nor is it suggested that the ‘specialised visitor’ is a substitute for all forms of specialised counselling. All that is being suggested is that there is a role for counselling in the lives of the aged, and that the ‘specialised visitor’ can fulfil an important role in providing the aged with an improved quality of life.

12.2 MEANING OF COUNSELLING

Counselling is, by definition, a service consisting of helping people to adjust to or deal with personal problems, etc. by enabling them to discover the solution to the problems while receiving sympathetic attention from a counsellor. It sometimes

¹ See Chapter Eight : The Resident : The Nature and Effect of the Ageing Process

² See Chapter Nine : The Resident : The Pre-institutionalisation Position

³ See Chapter Ten : The Resident : The Nature and Effect of the Process of Institutionalisation

⁴ See Chapter Eleven : The Resident : The Reasons and Causes of Institutionalisation

means no more than the giving of advice on miscellaneous problems.⁵ A counsellor is one who counsels or one involved in counselling.⁶

On analysis, the definition postulates (a) helping people (b) to deal with (c) personal problems (d) by enabling them to discover the solution to the problems and at the same time (e) receiving sympathetic attention from a counsellor.

Referring to the definition, a distinction must be drawn between the two types of counselling embraced. The one is a service offering help to which is linked the receiving of sympathetic attention from the counsellor. The other is the giving of advice on a particular problem.

There are many counsellors who have attained a sufficient degree of expertise in a multitude of disciplines to qualify them to be involved in counselling in all manner of situations. The most obvious of these is the barrister or advocate who by reason of his skills in the discipline of law is able to give to his client advice on a particular legal problem. It seems unlikely that such advice will be coupled with “sympathetic attention”.

It is not impossible that an aged person requires assistance of this nature. She has a problem and seeks advice. She is advised accordingly and this advice may or may not deal with her problem. The whole matter is purely objective and “sympathetic attention” does not fall within the ambit of the advice given.

While not excluding this aspect of counselling, what is envisaged is the offering of help to deal with personal problems by enabling residents to discover the solution to their problems by way of caring and sympathetic attention on the part of the counsellor. It is not suggested that it is only the “specialised visitor” that can offer

⁵ See *Chambers English Dictionary* (W. & R. Chambers Ltd and Cambridge University Press 1988); *The World Book Dictionary* (*supra*); *World Book Encyclopedia* Vol 8 p. 408; *World Book Encyclopedia* Vol.13 p. 332; Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age* (*supra*) p. 314; Neil J. Smelser: *Sociology (Fifth Edition)* (*supra*) p. 254; Neil J. Smelser: *Handbook of Sociology* (*supra*) p.110; Annaliese Pierskalla: *The Implementation and Evaluation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged* (*supra*) p. 48.

⁶ See *Chambers English Dictionary* (*supra*)

this means of counselling. Nor is it suggested that other forms of professional counselling are incapable of dealing with personal problems or are lacking in care and sympathetic attention in endeavouring to offer a solution to the problems of the aged.

What is suggested is that the form of counselling being offered incorporates the following: (a) the time and inclination to listen to the personal problem, however minor and superficial it may appear to be (b) to appreciate the nature of the problem and that it is causing disturbance on a personal level (c) to analyse (and if needs be, to debate) the problem and determine the measure of the disturbance it is causing (d) to respond in an intelligent (and if needs be) and profound manner (e) to advise in a thoughtful and responsible manner, and if this is not possible immediately, to do so after seeking appropriate information; and (f) to follow-up the incident.

12.3 ACCEPTANCE OR REJECTION OF COUNSELLING

Before proceeding with the subject of counselling, it is important to bear in mind that counselling must not be seen in isolation but in relation to residents generally, or to a specific resident. It is, by definition, a 'service', and it is a 'service' which is directed at 'helping people'. Moreover, it is not just a case of 'helping people' but helping people 'to adjust to or deal with personal problems'.

Taking the definition no further, enough has been said to indicate that it is personal and sensitive issues that are at stake. The service of helping people may well be directed at someone who is old and feeble, indeed, it may even be directed at someone who is mentally or intellectually frail, but this does not mean that anything less than 'sympathetic attention' must issue from the counsellor.

Moreover, it is open to the resident to accept or reject the counselling being offered. Even if a personal problem is raised by a resident, and even if counselling is entertained initially, but the subject is later closed by the resident, that is the end of the matter, however much time may have been wasted.

The counsellor may have knowledge of a particular problem being borne by a resident, or it may have been suggested that he ought to counsel a resident on some particular matter, but if the resident declines to raise the matter or to discuss it, then the service of counselling does not arise. In this regard, whatever may be the physical or mental condition of the resident, she has a right to privacy, and moreover, whatever may have been spoken by the resident or some third party in confidence, remains confidential. It is not open to a counsellor to betray confidences; nor is it open to him to impose himself on a resident who chooses not to avail herself of the service the counsellor is offering. Acceptance or rejection of counselling is a matter peculiar to the resident who is free to express herself in whatever manner she best sees fit.

12.4 NEED FOR COUNSELLING

Whether or not a resident is in need of counselling is difficult to determine objectively. Invariably, the resident is harbouring personal feelings, emotions and problems. In certain cases, these are detectable, in other cases, they are not. Unlike residents who are suffering from physical, mental or medical problems, which can be diagnosed (and therefore treated) scientifically, residents with personal and emotional problems must 'suffer in silence', subject to one exception.

That exception relates to regular and continuous contact with the resident; the building up of a special relationship; of being able to talk and to discuss matters on a meaningful level. This leads to a two-fold result. One is that the counsellor can often detect, in the demeanour, attitude and conduct of the resident, that 'something is wrong', thus opening the way to sensitively probing the problem and discussing the matter. The other is that, a meaningful relationship having been built-up, the resident is prepared to talk and thus open herself up to counselling.

The need for counselling, and the counselling opportunity, may be illustrated by referring to three situations. The first is the 'major disaster situation' such as a high-profile shooting or rail accident where a number of people have been killed, injured or emotionally shocked. Naturally and urgently a team of trained counsellors move in to counsel those who have sustained physical or emotional shock. The injured and the traumatised respond to face-to-face counselling or resort to help lines. The second is the 'crisis generated situation' such as a crucial or decisive moment in a marriage relationship or a time of difficulty or distress leading to an emergency such as threatened suicide. This is not high-profile or public but nonetheless critical in the life and experience of the person concerned. So much so that they resort to help lines and seek the advice, guidance and direction of a trained counsellor. The third is the 'isolated suffering individual' situation where the person concerned thinks anxiously for hour upon hour and meditates silently in her solitude. There is little or no drama; no calamitous action threatened; no public demonstration. It is essentially a private, brooding, meditative experience.

It is this third situation that gives rise to a need for counselling among the institutionalised aged and it is to this set of circumstances that counsellors must apply themselves to the benefit and upliftment of the residents.

12.5 COUNSELLOR, FAMILY AND RESIDENT

No great emphasis is placed upon the family at this stage as attention will be given to them in due course.⁷ The point that is made is that the counsellor, or, as will be contended, the 'specialised visitor', does not operate alone, or, in isolation. Certainly, he bears a confidential relationship to the resident and is not free to make public what has been disclosed to him confidentially. At the same time, he works with and for the resident, to the ultimate enhancement and improvement of her quality of life. He also works with and for the family of the resident, if she has one, and if the relationship is cordial and affectionate. Where it is not, it falls to him to

⁷ See Chapter Thirteen : *The Family : its Role before, during and after the Institutionalisation Process*; Chapter Fourteen : *The Family : its Role in meeting the physical, mental and emotional needs of the resident; and its ability to provide informal counselling*; and Chapter Fifteen : *The Family : its relationship with the resident and with the Institution*

try and affect an improvement, and if possible, a reconciliation. Whatever may be the attitude of the resident, the counsellor or 'specialised visitor' must try not to antagonize the resident against her family.

Moreover, the counsellor, or 'specialised visitor' must not act in opposition to the administration, or counteract the action of the Board of Trustees. Ideally, the counsellor or 'specialised visitor', the family, the resident, the administration and the Board of Trustees, should work in unison and harmony with the view to the benefit of the quality of life of the resident.

The administration, in particular, can be a source of valuable information to the counsellor or 'specialised visitor' in relation to the resident. They are possessed of all manner of helpful advices which they are always willing to impart and which can be of untold benefit and advantage to the counsellor or 'specialised visitor'.

12.6 ALTERNATIVE TO COUNSELLING

The important question that arises is whether there is an alternative to counselling, either by a counsellor properly so called, or by a 'specialised visitor'. There are associated questions: What happens to the resident who is faced with problems and difficulties? Who offers to her assistance to deal with her personal problems? Who gives to her the sympathetic attention she requires or desires?

The question admits of an easy (but not complete) answer. What happened before the advent of the counsellor or 'specialised visitor'? Who, then, assisted the resident with her personal problems? The answer to these questions is that it fell to the lot of the General Manager and the administration to counsel and to visit the residents. This gives rise to further questions. In the absence of a counsellor or 'specialised visitor' does the matter of counselling and 'specialised visitation' become the problem of the administration, and if so, what about the pressures and the time constraints? This leads to the incompleteness of the answer.

The administration readily admits that it is part of their administrative role to give to the residents attentive service; to perform duties, to supply or do things needful and to proffer kindness. Moreover, this they do in abundant measure, often to their own inconvenience and trouble. But, at the same time, they also readily admit that they do not have the time to do all that they would like to do, or feel led to do.

Accordingly, they look appreciatively to the 'specialised visitor' who works with them and alleviates the pressures in areas they know and accept to be vitally important.

The alternative to counselling is a possibility but it is not a satisfactory alternative and does not enhance or improve the quality of life of the residents.

12.7 SUBJECT MATTERS OF COUNSELLING

The subject matters which, hitherto, have occupied the mind of the 'specialised visitor' have all been post-institutionalised matters. In respect of new residents they have largely been directed at assisting in the adjustment to the institutionalised life. In some instances, this has been a comparatively easy task, as the new residents have comfortably and enthusiastically adapted themselves to the new situation and settled-in well. In other instances, it has been a very difficult exercise. The resident may, genuinely, be unable to settle-down; in some cases, she incorporates her own volition and makes up her mind, whatever the circumstances, not to accept the new home, and, come what may, not to adapt to the new environment. But whatever the situation, the lot falls to the 'specialised visitor' to use his best endeavours to incorporate the new resident, happily, into her new home.

In respect of established residents (the longest of whom approaches twenty five years as a resident of the Home) the first objective is to get to know them; to

befriend them; to ascertain their backgrounds; and to be comfortable in their presence. The second objective is to engage in meaningful conversation and so build-up confidences which can be trusted and relied upon. The third objective is to help them deal with personal problems in a sympathetically attentive atmosphere. The attainment of these objectives is no easy task but the factor which goes a long way in reaching them is regular and continuous contact. It is said the ‘familiarity breeds contempt’; this may be so, but it also breeds ‘trusting confidence’.

The question arises as to whether counselling can be confined to post-institutionalised matters. It can. But it makes such counselling, in certain cases, much more difficult. In at least two respects, it is suggested that pre-institutionalised counselling would be beneficial. The first respect relates to an adequate preparation for the institutionalised life. In a number of instances, it has become apparent that little or no preparation for the institutionalised life has been done. The final stages, particularly, were hurried, as a result of which, the resident was still clinging to the pre-institutionalised position, and completely unprepared for her new home. This brings one to the second respect, namely, adequate preparation for the leaving of the pre-institutionalised position. In many cases, this has been the essence of home for more than half a lifetime. In but a short while, it is all gone, and something radically different is substituted. The resident is required to be resolute and fortitudinous. If this is to be the case, then adequate preparation must be made and appropriate counselling must be offered.

12.8 WHO IS TO DO THE COUNSELLING?

It is proposed, under this head, to deal with pre-institutionalised counselling only. Post-institutionalised counselling will be dealt with later in this chapter under the heading “The Specialised Visitor”. The subject matter of the pre-institutionalised counselling has already been adverted to, and all that remains is to say a word about the persons who could do the counselling.

The first person who comes to mind, if the resident has an association with the church, is a spiritual advisor, or a clergyman. These people usually have knowledge of the structure and function of old age homes, and possess an ability to counsel a would-be resident. Depending upon whether he has a good relationship with the resident, he will know where the resident is emotionally and how she sees her situation. He must be careful to respect the resident's feelings and thoughts but, at the same time, if it is in the interests of the resident to be institutionalised, to use his resources and powers of persuasion to lead her in the right direction.

The other person who may be able to assist in counselling the resident is the family doctor. A word of caution must be sounded here as the more modern doctors are not accustomed to visiting people in their homes. Moreover, their times are usually limited and the charges can be high. But if these problems can be overcome, he may well be of assistance. He is not only acquainted with the elderly but has knowledge of the institutionalised position. In addition, he will probably have experience and expertise in counselling.

The third person who comes to mind is a venerated member of the family or a revered family friend. Usually, but not always, he (or she) is a person of great wisdom and sound of judgement. As to whether he possesses skills in the art of counselling is a matter to be determined. Nonetheless, the elderly may well have respect for a person of wisdom and discernment. A gentle but firm approach may well have the desired effect, and a head full of wisdom may compensate for a mouth full of skillful words.

Whoever may be the person chosen to do the counselling, he must show the resident he cares by coming regularly to talk and to listen to her. Rapport must be established and the counsellor must be sensitive in responding to the resident's changing moods and attitudes. A special concern of the counsellor will be to help the resident see that there can be value, comfort and security in institutionalisation.

12.9 WHEN MUST COUNSELLING BE DONE?

A brief word will suffice under this head. It has already been noted that counselling is advised both before and after institutionalisation. Again it is said that post-institutionalised counselling will be dealt with in due course.⁸ As to when pre-institutionalised counselling must be done is a matter which depends upon the circumstances, especially upon the attitude taken by the resident and the convictions she harbours relating to leaving her own home, and taking up residence in the Home.

Moreover, a key factor is her physical and mental condition. Consequently whatever may be her attitude and her convictions relating to her old and new homes, her physical and mental condition may be the decisive factor.

In answering the question as to when the counselling must be done, the duration of the counselling must be taken into account. The object of counselling is to help people to deal with personal problems. At the same time, it is linked to 'sympathetic attention' from the counsellor.⁹ But a would-be resident can be obstinate and stubborn, totally unyielding in a situation where, objectively viewed, institutionalisation would be in her best interests.

Accordingly, while time, patience, and sympathetic attention may be key factors, the duration of pre-institutionalisation counselling may have to be curtailed by the prevailing condition of the resident.

12.10 THE 'SPECIALISED VISITOR'

For a period of two years the greater part of the post-institutionalised counselling has been done by the researcher. It is he who initiated and developed the programme of visitation; it is he who assumed the role of the 'specialised visitor',

⁸ See under the heading : "The Specialised Visitor"

⁹ See (*supra*) under heading "Meaning of Counselling"

and it is he who pursued this investigation with the view to advancing the contention that, save in a sphere where the expertise of qualified counsellors are required, the 'specialised visitor' fulfils a role and function of improving and enhancing the quality of life of the institutionalised aged. The basis of this contention is that the 'specialised visitor' (a) is in regular and continuous contact with the residents (b) through this regular and continuous contact, he has achieved a familiarity with the residents that enables them to seek his advice and guidance on personal problems (c) he is not bound by time or administrative procedures, so that he is readily available to the residents (d) with his qualifications, experience and expertise, he had proved himself suitable to fulfil the role of 'specialised visitor'; and (e) he has achieved a degree of acceptability among the residents to the extent that they can confide in him and entrust to him their personal problems.

12.11 CONCLUSION

The resident must not only be investigated in the various contexts that have been referred to, but must be examined within the context of the family. Accordingly, attention is now directed at Section E which deals with the family. In Chapter 13, regard is had to the role of the family before, during and after the institutionalisation process. In Chapter 14 consideration is given to the role of the family in meeting the physical, mental and emotional needs of the aged person, and its ability to provide informal counselling. In Chapter 15, thought is given to the interrelationship of the family with the resident and the institution.

SECTION E. THE FAMILY**Chapter 13. THE ROLE OF THE FAMILY BEFORE, DURING AND AFTER THE INSTITUTIONALISATION PROCESS****13.1 INTRODUCTION**

Most of the residents at the Ladies Christian Home are widows. A few are spinsters. A very small number, if any at all, have nobody to take an interest in them. Most have families, or, at least, close friends or confidantes. Those with families often have children, grandchildren and even great-grandchildren. For some the family bond is very close and a happy united relationship is detected. For others, although not readily admitted, the relationship is strained, and often unpleasant. One daughter telephoned the administration to say that she intended not to visit her mother anymore as the visits were invariably tension-filled and upsetting. In certain cases there are fixed weekly arrangements when a daughter takes her mother for an overnight visit; or, at greater intervals, there are daughters who take their mothers for a week-end visit, especially when there is a family celebration. Strange to say, some residents speak fondly of sons-in-law. Others, regretfully, have few visitors and fewer visits but it is hard to detect whether they are lonely as residents, as by and large, they are inclined to frequent their own rooms by themselves. A single pattern does not clearly emerge but manifestly, in the greater number of cases, the family is a cherished aspect of life.

13.2 THE ROLE OF THE FAMILY BEFORE INSTITUTIONALISATION

One must go back over the years to the time when a husband featured in the life of the resident. He is not often spoken about, probably because he has been dead for some time, but clearly he was a central figure in the pre-institutionalised position. He must be seen in the context of the immediate family who themselves are grown-up, have children and possibly grandchildren and, themselves, are approaching advanced age. But the resident sees herself, with her husband, against the background of this family unit; through dimmed-eyes she sees the children growing up still, and the pre-institutionalised dwelling as the family home.

Home was more than a house, it was the centre of the family circle. Here, everything of importance occurred. Here, birthdays were celebrated, engagements took place, and the daughter left for the church to be married. Here, the resident, as a proud grandparent, gave the baptismal celebration. It was a hive of activity, the children played, listened to the radio and the gramophone, and entertained their friends. It was full of happy memories.

There were also the sad times. Childhood tragedies as romances broke-up, the first news of a pending divorce, the drama of a broken leg, and sorrow of a premature death. The home was life's tapestries of colourful events, of triumphs and defeats, of laughter and tears, of events light and burdensome.

It was here that the years gradually took their toll. It was here that people grew older, and it was here that the head of the home passed along, leaving the resident to fulfil the role of matriarch. It was here that she lived alone, and it was here that she grew old. It was here that the first traces of forgetfulness manifested themselves. Home, the place of levity and laughter, gradually became the proverbial millstone. As reluctant as were the family to admit it, the resident had become frail and feeble. She could not admit it. The home meant too much. The memories could not be forgotten and it was mindless to suggest that she could not cope. She had managed adequately over many years. How could it now be suggested that the home was "too much for her". But it was suggested. And angry scenes followed.

13.3 THE ROLE OF THE FAMILY DURING INSTITUTIONALISATION

It is not suggested that every resident is unhappy and distressed at being institutionalised, or, more properly, being admitted to an old age home, and that, proverbially speaking, she is dragged there 'kicking and screaming'. Many are most happy at being admitted to their new home; are delighted with the room allocated to them (usually pre-selected); and quickly adjust to become most cordial and friendly residents.

At the same time it is readily admitted that many residents are most displeased at the prospect of being admitted to an old age home. Often they manifest a most stubborn and obstinate attitude. They refuse to listen to (let alone accept) any suggestion that they are incapable of running the former home or that the home is too big or too difficult or too expensive to maintain. They resolutely refuse to accept any suggestion that their memories are anything other than they always were; that their physical strength is anything other than it always was; and that they are anything other than the person they always were.

Arguments regarding her inability to continue to look after herself in the former home and the benefits that institutionalisation hold out for her, are all to no avail. A resident can become vociferous. She can even become violent and abusive. She can be scandalous in her allegations. The suggestion that gaol is to be preferred to an 'old age home' is commonplace. More dramatic but no less expressive of the deep resentment and bitterness that seethes within the breast of the recalcitrant resident is the utterance: "If you want me to die, why don't you kill me?" or equally, "I shall die and it will be upon your conscience."

It is the family (together with the aiders and abettors) who must bear the brunt of this vituperation. Some react with calmness and equanimity while others meet aggression with aggression. Two things slowly but surely manifest themselves. One is that many harsh words will be spoken and many tears will be shed. The second is that the best interests of the resident must and will succeed. Assuming that it is in the best interests of the resident to be institutionalised, then there are a number of bridges to be crossed, and leading the way is the family. Some of these bridges will be adverted to; the manner in which they are crossed lies with the family.

The first, but not necessarily the easiest, is the choice of a Home. Here, a number of factors come into play. One is the finances. Homes, do not come cheaply, and even the indigent¹ face difficulties. This often entails the realisation of the fixed assets

¹ See Chapter Thirty-four : *The Visitor : Cultural and Gender Matters; and the matter of Indigence*

(the home) of the resident and the substitution thereof with income bearing investments. It is not always easily accepted by the family in that they foresee the possibility of their inheritance being frittered away. Truth to tell, where indigence plays a role, this is often an area of dishonesty and shameful conduct. But be that all as it may. The worst is yet to come. If institutionalisation is the only course, and finances give rise to problems, it may well be that the family must make up the shortfall. Just as residents and families encounter financial hardships, so do institutions, and in these days of reduction in Governmental subsidies, it is becoming more difficult for institutions to make ends meet.²

The second is locality. Often the locality of the Home determines the language which predominates. It determines the facilities that are available such as post offices, banks, shops, churches, and so on. It is also important from the point of view of the services that are offered to the Home i.e. library services, charity services such as Rotary and Lions Clubs, and religious services by way of Bible Studies, divine Worship, and the sacrament of communion.

Of perhaps greater importance than all these, the locality of the Home determines the ability of family and friends to visit regularly. The significance of this factor cannot be overemphasised. The choice of the Home may fulfil many criteria but if it leads to the isolation of the resident from her family and friends, the choice is unsatisfactory.

The third is a gender matter. All the essential criteria may be met but the Home caters for ladies only, and the would-be resident is a man. If the Home refuses him admission it may give rise to a constitutional crisis but this will be considered in due course.³

² See footnote 8 of Chapter Seven and Annexure C 1 hereto

³ See Chapter Thirty-four : The Visitor : Cultural and Gender Matters; and the matter of Indigence

The fourth involves assessment and judgement; the Home must be a good one. It must be clean, it must be pleasant, it must have a good table; the nursing services must be excellent, and the residents must be well looked-after. Institutionalisation is not a 'dumping exercise' where anything goes. It is a means of ensuring that the quality of life of the person concerned is enhanced and improved as the final years of life are lived out.

The choice of Home having been made, leads to the second, and no less easy bridge, namely, that of convincing her that to take up residence in that Home is not only the right thing to do, but also in her best interests. It has already been conceded that this is no easy task. If the family cannot succeed, then professional advice must be enlisted.⁴ High-handedness and confrontation cannot be excluded but must only be resorted to as a final recourse. It must always be remembered that the resident is of advanced age with, perhaps, only a few years to live. Nothing must be done that will permanently sour the relationship and lead to lasting regrets.

The third bridge, like the others, is difficult. It involves disposing of the erstwhile family home, and the family treasures, the value of which may be sentimental only. This usually has to be done for financial reasons. For the resident it can be heart-rending and traumatic. Although largely a commercial venture, it must be done sensitively and with dignity. "Grabbing" must be avoided at all costs, for this is a memory which often abides with the resident to her death. Do her the honour of taking such as can be taken, to the Home, and what cannot, let her dispose of with grace and dignity. Moreover when the storehouse has been garnered, and she has the capacity to understand and appreciate, do her the honour of knowing what is rightly hers, how it will be used; and by whom it will be managed for her benefit.

Bridges don't come easy, and the fourth is no easier than the other three. It is the transfer (not removal) of the resident to her new home. This, to repeat a phrase,

⁴ See Chapter Twelve : *The Resident and the Need for Counselling*

must not be a 'dumping exercise' or anything that closely resembles it. The family should assist the resident in choosing a room (if this can be arranged), assist her in furnishing the room, including as many items as the room (and Home) will permit, assist her in making acquaintance with her neighbours, assist her in orientating herself in her new surroundings; and assist her in adjusting herself to her new environs.

13.4 THE ROLE OF THE FAMILY AFTER INSTITUTIONALISATION

The role of the family is not terminated with the institutionalisation of the resident. She, herself, will be uncertain of many things; the layout of the institution, the various programmes offered by the Home, the role and function of the various members of the staff; and her association with the administration. She will only slowly build-up friendships, and her acceptance into established groups will be gradual. Colloquially speaking, she is the 'new girl on the block' and will be reluctant to assert herself. She needs support and she needs people. It is here that the family can be of assistance.

Firstly, they must be regular and constant with their visitation. These visits must not be formal and of short duration. They must be to the resident and to her neighbours. They must acquaint themselves with the place, the staff and the administration. The resident must not be perceived as a neglected 'loner'. Where permitted, or possible, they must partake of the activities of the Home, they must associate themselves with the resident and with the Home. As they gain recognition and acceptance, so the resident will become more recognised and accepted. The association with the Home cannot be overemphasised. If they can offer their assistance in any way, they must do so. Confidence on the part of the family will spill-over to confidence on the part of the resident. But regularity and constancy are the watchword. Failure to turn-up when expected; or turning-up late for an appointment; or telephoning at the last moment to cancel, all lead to uncertainty, insecurity, and the feeling of rejection.

Nor must it always be the same members of the family who visit, with regular excuses from those who do not attend. Moreover, the more the number, the more the input and participation. The family must not retreat, or hold-back, or fail to demonstrate a continuing interest and concern. If the family fail, who else is there?

Secondly, contact with the resident must not be confined to visits, however regular and constant they may be. The resident must be (if her physical and mental condition allows) important enough to take her out. These outings need not be expensive but they must be special; they must be arranged in advance, and the programme must be made known. They must be of such a nature that the resident can speak to her friends in anticipation of the outing, and afterwards, to tell her friends of the places she had visited or the people she had met.

Her new situation must approximate the pre-institutionalised position. She must be reinstated as the matriarch and activity must take place around and about her. This will make her feel a part of the family still, and not isolated from them. She must never feel left out of the family scene.

Thirdly, from time to time, and especially on special occasions, she should (if her condition allows) be invited to sleep over at a family member's home. This gives her opportunity to select pretty clothes, to prepare herself physically, to pack her suitcase, and tell her friends that she has been invited 'to stay over'.

Moreover, on her return she will have much to recount concerning the experiences she has enjoyed, and especially the event in which she was invited to partake. This entirely rules out the 'dumping process'. Indeed, it goes a long way to restoring her to the position she occupied in the pre-institutionalised situation.

Fourthly, she must not be the hidden member of the family; she must always be on display as the matriarch. She must be given the opportunity, and encouraged, to meet the members and appurtenances of the extended family. However difficult it

may be, meetings of the extended family should be arranged, with the resident as the central figure. Wives and girl or boyfriends must be invited and encouraged to attend. The resident should be photographed with children, grandchildren and great-grandchildren; boy and girlfriends must be encouraged to stand with her and next to her. Moreover, the photographs should be expeditiously processed, and suitably inscribed on the back, so that the resident can show them to friends and neighbours, and be able to make intelligent comment thereupon.

What has been described happens, not as the rule, but as the exception. The researcher advances the contention that such conduct on the part of families will greatly enhance and improve the quality of life of residents. Obviously it cannot be done in all instances and is, to a very large degree, confined to those who are well enough to participate.

13.5 CONCLUSION

The family plays a pivotal role at all stages of the institutionalisation process. It is encouraged to greater and more intimate participation. Not the least of this participation relates to the physical, mental and emotional needs of the resident and to the ability of the family to become so involved with the resident that they might embark upon the provision of informal counselling. It is to this matter that attention is now directed.

Chapter 14. THE ROLE OF THE FAMILY IN MEETING THE PHYSICAL, MENTAL AND EMOTIONAL NEEDS OF THE RESIDENT; AND ITS ABILITY TO PROVIDE INFORMAL COUNSELLING

14.1 INTRODUCTION

It has been observed that the role of the family in the process of institutionalisation is crucial. It is not limited to any particular stage but covers the whole spectrum of the activities embodied in the process of institutionalisation. This chapter, like the last,¹ is focussed on the family. Not so much from the point of view of the institutionalisation process, but from a more personal perspective in relation to the resident within the context of the institution. It is accepted that the multitudinous problems that presented themselves up to, and including the transfer into the Home, have been overcome, and that the resident has been relocated. It is not accepted that thereby all the problems relating to the resident (and the family) have also been overcome. Indeed, the chapter presupposes that a new set of problems emerge and that the role of the family in seeking to provide a resolution to these problems, is no less crucial.

There is a question that needs to be answered before considering these matters. It relates to the role of the family in the discharge of their primary duty of caring for an elderly member of the family. Is it not the responsibility of the family to attend to the needs of an ageing or aged member? This presupposes an ability on the part of the family to care for an aged member. Where such an ability exists, and especially where the older person lives an active, healthy and independent life, the family is the core of the support systems for the elderly. This accords with official policy². Indeed, according to official policy, the basic principle underlying ageing is to enable older persons to live active, healthy and independent lives for as long as

¹ See Chapter Thirteen : *The Family : its Role before, during and after the institutionalisation process*

² *White Paper for Social Welfare. Notice 1108 of 1997. Government Gazette No. 18166. 8 August 1997. Section 77 on p. 71*

possible, aided and supported by the family³. The contrary situation is more pertinent. This situation relates to the elderly who are frail⁴. Here, two aspects of official policy are apposite. The first is that the Government accepts a responsibility to provide for the needs of disadvantaged, destitute and frail older persons who require 24-hour care and who do not have the financial resources to meet their own needs. The second is that the Government acknowledges a need for Homes for older persons who are frail⁵.

In considering the role of the family in relation to their primary duty of caring for an elderly member of the family, a distinction must be drawn between an older person who lives an active, healthy and independent life, and one who is frail and in need of care. In the former case, there is a responsibility on the part of the family to attend to the needs of an ageing or aged member, whereas, in the latter case, that responsibility is discharged on the basis that the family, in the exercise of its ordinary, usual and normal role, cannot effectively care for the aged member. This, within the context of physical, mental and emotional needs of an ailing member of the family, gives rise to the need for institutionalisation.

The family must be viewed in three phases. First, and this is pre-eminent in the thought patterns of the resident, is the family as it was, that is, the early family as it grew up and expressed itself in the context of the home. Secondly, and this can also loom large in the way the resident thinks, is the later family, especially as it manifested itself in the process of institutionalisation. On the one hand, it can give rise to appreciative, grateful and comforting reactions on the part of the resident. On the other hand, it can give rise to resentment, bitterness and anger as the resident denounces the family with censure, revulsion and abuse.

³ *White Paper for Social Welfare. See fn. 2 supra*

⁴ *White Paper for Social Welfare. Notice 1108 of 1997. Government Gazette No. 18166. 8 August 1997. Sections 82 (c) and (d).*

⁵ *White Paper for Social Welfare. See fn 4 supra.*

Thirdly, the family as it now is, in its post-institutionalised role. This involves personal contact with the resident (on a basis which is as regular as the family chooses to make it); it involves talking to the resident, building up a meaningful relationship in a new context, comforting and encouraging the resident; and where the opportunity presents itself, to offer sympathetic attention in the form of sound advice and guidance.

It may admit of a simple answer but a question, nonetheless, arises, and it is important, as it holds far-reaching consequences. The question is: who is the family?

14.2 THE FAMILY

It is easy to err by approaching the question from a wrong perspective. The family must be determined, not from the point of view of the family, but as the resident sees and appreciates it. It is to be seen, not from a matter-of-fact, ordinary point of view but from the point of view of the emotions, the feelings, and the memories of the resident. It is not the family, as it is technically and objectively viewed, but the family, as it existed and grew over a period of time; and as it is nurtured and treasured in the heart and mind of the resident. This is not sentimental verbiage. This is a matter of acceptance or rejection; a matter of relocation or 'dumping'; a matter of caring concern or a matter of 'getting out the way'. In the end, the resident wants to know, in action and deed, whether she is still loved, honoured and respected, or whether she is merely being tolerated until her days on earth are done.

The family, first and foremost, consists of a patriarch and matriarch. True, the resident's husband is dead. But only physically. In terms of the past, in terms of memories, in terms of the family as it was, there was a mother and a father; a patriarch and a matriarch. The patriarch is dead, and the matriarch is institutionalised. Is she still a member of the family?

The family, secondly, consists of an immediate family; these are the children, most of whom, if still alive, are of advanced age. But they are still her children, and as such, part of the family. It is to be observed that residents refer to the death of a child as though it happened recently, whereas, in fact, it happened decades ago. Moreover, children are referred to as though they were teenagers (although now of advanced years); and financial assistance is given (sometimes from a paltry pension) to a child (similarly of advanced age) as though the resident was still obligated in this regard. Sons and daughters are still viewed in the context of the family as it existed, and as it is still remembered.

The family, thirdly, consists of an extended family; the spouses of children, their children, and often times, their spouses, as well as the grandchildren. The matter may be taken further, even to great-grandchildren. These, all, comprise the family. These all are the esteemed relatives of the resident, and these all are recalled and remembered (where the intellectual capacity permits) with affection and pride.

But the family goes further. Where generation has followed generation; children have been born, marriages contracted, and grandchildren have arrived, the family extends to the potential members, that is, boyfriends and girlfriends (however tentative these relationships may be).

The argument that is being advanced is that when it comes to assessing the role of the family in relation to the resident, it is not just an occasional visit by a close relative. It is a role that devolves upon the family at large, to share in the life and experience of the resident to the ultimate enhancement of the quality of life of the resident.

14.3 THE PHYSICAL NEEDS⁶

The inquiry proposed is two-fold: what are the physical needs of the resident, and what role can the family play in meeting these needs? The first observation to be made is that the physical and medical care of the resident is fully and decisively in the hands of the medical staff of the institution. It is the senior sister and her staff who monitor the condition of the resident and who keep careful records of this condition. If needs be, the position is referred to the medical doctor. In consequence, it is not, in any shape or form, suggested that the family should usurp, or attempt to usurp, the role and function undertaken by the medical and nursing staff. The second observation to be made is that the prescription and dispensing of medicines or drugs to and for residents are in the hands of the nursing and medical staff. This must be the case and cannot be otherwise, except at a considerable risk to the resident. It may be that a member of the family can obtain medicines or drugs more cheaply and it may seem clever to obtain for the resident drugs or medicines surreptitiously. But this is inadvisable and could place the resident in grave danger. If the family are dissatisfied with the nursing or medical procedures, then there are adequate and appropriate means whereby these procedures can be reviewed, and, if needs be, revised. The role played by the family in meeting the physical needs of the resident cannot and must not be an interference with the role played by the medical or nursing staff.

The role that can be played by the family in meeting the physical needs of the resident is something different. It is an auxiliary or passive role. It is an assisting role whereby the family draw alongside the nursing and medical staff and fulfil a function which favours the general well-being of the resident.

⁶ Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age* (supra) at p. 79; Anneliese Pierskalla: *The Implementation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged* (supra) at p. 18; *The World Book Encyclopedia* (supra) Vol. 1 p. 131; *The New Illustrated Medical and Health Encyclopedia* (supra) Vol. 1 at p. 98; Neil J. Smelser: *Sociology (Fifth Edition)* (supra) at p. 255.

The role that can be played by the family in meeting the physical needs of the resident depends, to a very large extent, on the physical condition of the resident. It also depends upon the physical condition of the family member. Situations do arise where, in good faith, the family member embarks upon an activity for which she is not capable. This can lead to a dangerous situation for the resident and for the family member.

Where a resident has limited mobility, such as being confined to a wheelchair, a member of the family (who is able) could take her for a walk around the garden, or around the premises; or seat her in a sunny spot and converse with her. But to assume the role of the physiotherapist and encourage the resident to come out of the wheelchair and engage in walking exercises would be most unwise. Often the family member thinks that her contribution is too minimal to be of any use, and ceases with her efforts. Her efforts may be minimal to the family member but to the resident it is important as someone who is showing an interest and a concern, and who is putting herself out for the benefit of the resident.

Likewise, the resident who has impaired vision. Taking her for a walk around the premises or the garden, or reading a magazine or newspaper, or sharing with her in playing bingo, may seem to be an insignificant contribution to the welfare of the resident. But the significance lies, not so much in the deed or act, but in the fact of taking an interest in a person; of taking the time, of putting oneself out in the interests of another. Taking time and trouble is often underestimated. It is suggested that this may be a reason for failing to visit, or visiting irregularly, or rushing a visit.

The visitation of those with impaired hearing can be an exhausting endeavour. So much so that the deaf are often avoided, and left to cope with their world of silence. But because they are deaf does not mean that they are not people with interests, emotions and concerns. Moreover, the fact that it may leave the family member drained because of the sustained effort during the visit, should not be a reason for

forsaking the resident. Ways and means can be devised whereby time is profitably spent together without trying (usually in vain) to make oneself heard. Sharing in the perusal of a newspaper or magazine, or (with permission) doing some gardening or even walking around the garden pointing out objects of interest, can be a means of fruitful and appreciated communication. Moreover, the end result is less exhausting.

Often the physical condition of the resident is more of an embarrassment to the family member than it is to the resident. More time is spent on hushing the loud voice of the deaf communicator, than in the exchange of friendship and love. Likewise, the unsteady step and slow gait of the partially-sighted. Perhaps the greatest source of the visitor's distress is the consequences of the resident's incontinence. This is no less a source of embarrassment to the resident. It is easily dealt with by enlisting the assistance of a nurse-aid. But these factors, taken separately or together, present handicaps to the family member who, rather than face them, chooses to avoid the resident.

The need of the resident relates to her pre-institutionalisation position; she seeks her earlier standing as matriarch; she seeks the companionship and support of her children (family); she seeks their interest and time; she seeks continuity and regularity of contact; and she seeks inclusion in that unit of which she was an integral part. The role of the family is to meet these needs in a simple, unobtrusive, and genuine manner, as a central feature of daily life, and not just an optional addendum.

14.4 THE MENTAL NEEDS⁷

Again, the proposed inquiry is two-fold: what are the mental needs of the resident, and what role can the family play in meeting these needs? This is the area which gives rise to the greatest cause for concern to the family. The family, as reluctant as they are, are forced to accept that the matriarch is slowly, but certainly, losing touch

⁷ Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age* (supra) at p. 119; Anneliese Pierskalla: *The Implementation and Evaluation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged* (supra) at p. 16; Neil J. Smelser: *Sociology (Fifth Edition)* (supra) at p. 255.

with reality. That, possibly, a time will come when she no longer recognises or knows the persons who were nearest and dearest to her. As inevitable as the result may appear to be, they refuse to accept it, and constantly fight against it. The pattern of increasing forgetfulness, which already manifested itself in the pre-institutionalised position, has suddenly gained momentum. In trying to reduce the trend, and impose an absent memory, voices are raised, arguments are advanced, and tempers are lost. Depending upon the age of the resident it may lead to Alzheimer's disease, which is an illness of the mind leading to premature senile dementia, or it may lead to senile dementia itself. The fact of the matter is that the mind is being affected, and intellectual contact is being lost.

Another mental need of the patient, which presents itself in a few cases, is that of mild retardation. This manifests itself in a great need for time and attention. Even the most minor event must be discussed and observed. To be abrupt or impatient on the part of the administration, would be to be cruel. When time is expected, time must be given; and however demanding the resident may appear to be, a sensitive and sympathetic response must be given.

The ultimate need is to be discovered in the frail care unit where a goodly number may be described as *non compos mentis*. Here contact with reality seems to have ceased. The ability to communicate is no longer present. But they are still alive, and they are still people. What they can understand or appreciate is difficult to determine, but they cannot be ignored or disregarded or abandoned.

A variety of mental needs have been referred to. What role can the family play in meeting these needs? First and foremost, the family must not avoid them, or pretend they do not exist, or believe that there will be no further consequences. What is required is time, and understanding, and patience. Forgetfulness is a fact of life; it cannot be rationalised or argued away. It must be accepted and dealt with calmly

and sympathetically. Even when the resident can no longer remember the family member, this must not become a matter of debate, or argument, or attempts to revive what is past. Whether it be forgetfulness, or Alzheimer's disease, or senile dementia, the resident remains a person and must not be forgotten or abandoned.

The ultimate in caring and loving concern on the part of the family is manifested when the family sit for half-an-hour, or an hour, just holding the hand of the resident, or rubbing her arm, or her cheek. It will be a reckless judge who says that nothing is understood or appreciated.

14.5 EMOTIONAL NEEDS⁸

What are emotions and what are emotional needs? Who qualifies to harbour emotions or express emotional needs? And when does the time come when a person no longer qualifies? Are stress and depression, emotions which are reserved to those who are young of years and active of body and mind? Can a person whose wants of the body are cared for, and whose hours of the day are planned and programmed, and have nothing about which they have to worry, entitled to be disturbed emotionally?

When dealing with emotions and emotional needs, firm views and definite persuasions dissipate. When there is nothing left to which to look forward, or which admits of forward planning, or even of some measure of foresight, is a resident entitled to harbour emotions of hopelessness? What of a resident who is ninety-seven, and says she is tired; she sleeps all night, and rests all day, and still she is tired. She is tired, not for want of rest, but because she has lived too long. Is she entitled to harbour within herself, a genuine desire to die? At what end must the remainder of her life be aimed? Is aimlessness an emotion she is entitled to harbour? What, in the face of all these emotions and emotional needs, if she harbours a fear of dying? Is this legitimate, and what is the answer to these emotional needs?

⁸ Beth B. Hess and Elizabeth W. Markson: *Aging and Old Age* (supra) at p. 86 and p. 124; Anneliese Pierskalla: *The Implementation and Evaluation of a Reality Orientation Programme for the Frail Aged in a Home for the Aged* (supra) at p. 35.

What, if all she has every day, for all of the day, only the ability to read, and she says she is so depressed? Is she entitled to this emotion and to what needs does it give rise? What is the answer to the resident who day after day must suffer pain of the body, or tries to think why she is getting so forgetful? Is she entitled to harbour emotions of worry or anxiety?

If all these emotions are present with accompanying needs to be satisfied, what role can the family play in meeting these needs?

One is to visit regularly and consistently. Another is to build up a rapport which is genuine and, above all, acceptable. A third is to be able to talk about all manner of subjects, not the least of which are those emotions which are giving rise to needs. A fourth is to avoid confrontation and aggravation. A fifth is to manifest sympathetic attention and sensitivity to the needs expressed.

14.6 INFORMAL COUNSELLING

The terms are used advisedly; informal because the probabilities favour the proposition that the family members possess little or no skills in the art of counselling. Accordingly, the suggestion is advanced that a scene be set which provides for calm and gentle discussion, rather than confrontation and anger.

If this is to be achieved, the starting point is an attitude of sympathetic understanding, rather than antagonism and hostility. Secondly, a stage must be set that leads to an atmosphere wherein calm discussion can take place instead of argument and conflict. Thirdly, encouragement must be offered to live rather than merely exist, and in this regard, conscious effort must be made to offer something for which to live. Fourthly, certain sensitive issues should be avoided, unless raised by the resident. The disposition of goods, the matter of wills and succession, the

matter of failing health or death will probably lead to confrontation. Of course, but only in appropriate circumstances, the matter of a will may have to be raised, but preferably by some independent third person. Fifthly, deferring to the wishes of the resident is preferable to expressing one's own point of view. Sixthly, if there are matters raised which are beyond the expertise of the family, it should be suggested that some qualified person be invited to offer his counsel.

14.7 CONCLUSION

The role of the family in the process institutionalisation, as well as in the personal life of the resident is important. No less important is the relationship between the family and the resident, within the framework of the institution, and the relationship between the family and the institution. Observations on this topic will be made in the next chapter.

Chapter 15. THE INTERRELATIONSHIP OF THE FAMILY WITH THE RESIDENT AND THE INSTITUTION

15.1 INTRODUCTION

There are three elements which interrelate with each other and give rise to the process of institutionalisation. One is the family (on rare occasions, the resident herself without the intervention of the family), the second is the resident, and the third is the institution. Each is a separate, individual and independent component. Moreover, each, at all times, retains this essential nature. At the same time, they intimately interrelate, one with the other, in the process of institutionalisation, thus forming a combined whole in the interest and concern of the separate, individual and independent parts.

The institution maintains a separate and independent existence but as such it fails in its constitutional purpose and role. This purpose and role is only achieved as it interrelates with the family and the resident. Likewise, the resident and the family, while maintaining, respectively, a separate and independent existence attain the very purpose for which the institutionalisation process was intended, as they interrelate with each other, and with the institution.

The Constitution¹ sets out the ground rules for the existence of the Ladies Christian Home and the purpose for which it was founded. Therein is incorporated its Mission Statement and its Objects. It acts unconstitutionally where it disregards these constitutional injunctions. Moreover, where it abandons its constitutional mandate it forsakes the reason for its existence, and its mission.

¹ *The Ladies Christian Home Constitution paras. 1 to 4 (Annexure A)*

The family and resident too, expressly, subscribe to the Rules of the Home², and, by implication, in becoming a part of a much larger whole, the resident undertakes “to conduct herself in such a manner that life will be a pleasure to them and to others.”³ The success of the operation, and the ultimate benefit to the resident, relies upon a healthy interrelationship and interdependence between the various units of which the whole is comprised.

15.2 THE FAMILY

Invariably, it is the family who sets into motion the process of institutionalisation. It is a member of the family who initiates matters by telephoning the institution and speaking to the General Manager. It is the family or a member of the family who, in the initial stages, comes to visit the home, not only to look it over and gain an impression, but also to talk to the General Manager and to make inquiries. This may occur before or after the resident has been consulted on the matter of institutionalisation.

It is with the family that financial implications are discussed and the financial situation of the resident is ascertained. It is from the family that preliminary inquiries are made relating to the physical and mental condition of the patient. It is to the family that an application form is given, as well as a copy of the Rules of the Home. It is the family who are informed of all the vital aspects of institutionalisation, and it is to the family that the institution looks for compliance on the part of the resident. It is the family who are, effectively, applying for the admission to the institution of the resident, and it is the family who are required to make alternative arrangements, and remove the resident, in the event of institutionalisation not proving acceptable to the resident or satisfactory on the part of the resident. Thus if there is a failure by the resident to subscribe to the Rules of the Home, not only will the resident be required to comply, but the family will be advised of the non-compliance, with the view to them taking appropriate action.

² See Annexure : Rules of the Home (Annexure B)

³ See Annexure : Rules of the Home : Rule 1

In like manner, with the meeting of obligations (usually financial) it is to the family that the institution looks to secure compliance. This must not be seen as a 'suretyship undertaking' whereby the institution is ensured of payment of its fees. Indeed, the meeting of obligations is wide in its ambit and may apply to non-financial obligations that must be met. It is rather a question of interrelation and interdependence between the family and the institution in regard to the resident. The family negotiates, or makes the arrangements, for institutionalisation, the family knows, understands and subscribes to the rules, and the family becomes a party to the meeting of obligations. But the matters goes further.

Areas of conflict or potential conflict do present themselves from time to time. One such area is that of theft of the residents possessions or money. Reports are made by the resident but after careful search the missing possession or money is discovered. But thefts do occur. To make allegations or charges is an exercise in futility and leads to considerable unpleasantness. The rules are clear⁴ and the residents and families are warned that the resident ought not to possess large sums of money, jewellery or other valuables on their person or in their rooms. Despite this, thefts are reported, the family intervenes requiring action, and conflict between the family and the Home occurs.

Another area of conflict relates to aspects of the nursing services rendered. The family interposes, often in a hostile manner. Where wrongdoing can be detected or blame attributed to some person, appropriate action is taken, and if needs be, discipline is administered. It is not intended to convey that the family has no voice, or ought not to voice dissatisfaction, where appropriate. What is suggested is that conflict and confrontation be avoided and that disagreements be resolved in a civil and cordial manner.

It is excusable that the attitude expressed by the family is that the resident's interests supersedes all other interests. The institution, however, adopts the attitude that the Home is not operated in the interests of one individual but in the interests of

⁴ See Annexure : Rules of the Home : Rule 14

all. Here again, it must always be borne in mind that the family, the resident, and the institution are interrelated and interdependent; that confrontation and conflict must be avoided, and that civility and cordiality must be made to prevail.

15.3 THE RESIDENT

The resident never loses her individuality. She is always regarded as a person, whatever may be her physical or mental condition, with her own personality, entitled to have her rights respected, to be accorded dignity, to have her welfare attended to, and to be freed from danger, care, and fear.⁵ She may be forgetful, senile dementia may have set in, and she may be infirm and needy, but she is still entitled to her rights in terms of the Constitution.⁶

But she is not the only resident. She is one among many. She has rights in terms of the Constitution. So do the others. Others are bound by the Rules of the Home. So is she. She is entitled to expect that other residents will conduct themselves in a manner that her life will be pleasurable. Likewise, she is expected to conduct herself in a manner that the lives of others will be pleasurable⁷. She must have consideration for others and obey the Rules whereby she and others are bound.

There is an interrelationship and an interdependence between herself and the institution, and as such, with the other residents. She acknowledges and accepts the authority of the General Manager and her supervision over the Home. She, together with the other residents, are expected to respect the General Manager as well as other members of the staff, so that a pleasant atmosphere may be maintained in the Home⁸. In other words, she is obliged to avoid conflict, not only with the General Manager and other members of the staff, but with the other residents with whom she has an interrelationship and interdependence.

⁵ *The Ladies Christian Home Constitution para. 2*

⁶ *The Ladies Christian Home Constitution para. 2*

⁷ *See Annexure: Rules of the Home : Rule 1*

⁸ *See Annexure B : Rules of the Home : Rules 1 and 2*

Moreover, in terms of the interrelationship and interdependence with the institution and her fellow residents, she must not engage in any conduct or activity which places the Home in danger. To smoke secretly in the Home, or use electrical appliances without permission, not only endangers her own life, but the lives of her fellow residents, and the property of the institution⁹. Rights are accorded to her, but obligations are, at the same time, placed upon her. This is the nature and scope of the interrelationship and interdependence that exists between the resident and the institution.

15.4 THE INSTITUTION

The interrelationship and interdependence of institution, the residents and the family are determined, in the first place, by the Constitution of the Home. There is set out the basis of its existence and the purpose of its mission¹⁰. The obligations imposed upon the Home and the rights accorded to residents are clearly and unequivocally set out in the Mission Statement and the Objects of the Home.

The interrelationship and interdependence of the institution, the residents and the family are determined, in the second place, by the management provisions of the Constitution¹¹. Therein, in particular, is set out the purpose of the General Manager, the responsibilities imposed upon her, and the authority granted to her.

Once institutionalised, the resident can look to the institution for the provision of certain services in terms of the General Manager being responsible for the general welfare of the residents. This includes, but is not limited to, the entire ambit of the catering operation and the provision of meals; the house-keeping operation which embraces domestic duties, gardening and maintenance services, laundry benefits and the availability of a driver. The general welfare of the resident necessarily includes the provision of nursing, health and medical services.

⁹ See Annexure : Rules of the Home : Rules 15 and 18

¹⁰ The Ladies Christian Home Constitution paras. 1, 2 and 3

¹¹ The Ladies Christian Home Constitution para 4

Without prolonging the exercise, the resident can look forward to other facilities such as the services of an occupational therapist, a physiotherapist, podiatrist, a hairdresser, and an administration. While not included in the scope of facilities, the elderly ladies can avail themselves of a minister of religion, Bible studies, services of worship and the administration of communion.

Incorporated into the concept of interrelationship and interdependence, there is the availability of the General Manager and the Bursar, as part of the administration, to be channels of communication, the receivers of complaints, and the dispensers of advice.

15.5 CONCLUSION

This concludes the discussion on the subject of the family, not as an independent and isolated unit, detached from institution and the resident, but integrally interrelated to and interdependent upon the institution. The argument is advanced that the family, the resident and the institution, while respectively maintaining a separate, individual and independent existence, nonetheless together form an interrelated unit that work together in the interests of the resident and each other. The institution has been examined, as has the process of institutionalisation; the resident and the family have been investigated, and the stage has been set to embark upon an investigation into crucial aspect of this dissertation, namely, visitation. This is the subject-matter of Section F. It is dealt with extensively. The meaning and purpose of visitation is set out in Chapter 16. Chapter 17 deals with the need for visitation. The normal or regular pattern is analysed in Chapter 18, while the specialised pattern of visitation is dealt with in Chapter 19. The benefits and advantages of specialised visitation are enumerated in Chapter 20 and the facts and circumstances giving rise to a programme of specialised visitation are set forth in Chapter 21. There are both religious and secular aspects of visitation and these are considered in Chapter 22. There are clear and definite reactions to the programme of specialised visitation. Generally speaking the reception thereof is enthusiastic. This is further pursued in Chapter 23.

SECTION F. VISITATION

Chapter 16. THE MEANING AND PURPOSE OF VISITATION

16.1 INTRODUCTION

It may be suggested that with the relocation of the resident in the institution, the institutionalisation process has been completed. In a limited sense, this is true, in that the resident who was once resident in the pre-institutionalised position, is now resident in the institution. But in the broader context, it is not true. The resident is still part of the family, she is still engaged in the process of living, and she is still a personality, with feelings, emotions and problems. She cannot be cut-off, separated and isolated. Indeed, she stands to be nurtured, encouraged and comforted. This is the point where visitation is most sorely needed, where it is put to the test, and where its contribution to the enhancement of the quality of life of the resident is established.

Before dealing with the meaning and purpose of visitation, there are a number of general observations that must be made by way of introduction. The first observation is that a visit to a resident in an institution is not a coincidental, haphazard and aimless occurrence. It is an exercise, a practice, an operation, not just the passing of a few moments with 'some poor old dear'. The second observation is that the nature of the visit will very largely be determined by physical and mental condition of the resident. This observation must not be misunderstood. It does not mean that if a resident is in a poor state of health, either physically or mentally, any form of visitation will suffice. It simply means that the nature of the visit may have to take a different form from that of a visit to a resident who is physically and mentally healthy. It may well be that more time and greater effort is required to make the visit meaningful and achieve an intended objective. It must not be assumed that because a resident is in an advanced state of senile dementia, she is unaware of the presence of the visitor or that the visitor is making an effort to communicate with her.

The third observation relates to the situation that arises as the result of a visit. The situation must be controlled, it must not be allowed to control. This requires a brief explanation. A visitor who has taken the time and made the effort to visit a resident must use the visit to the best advantage of the resident, she must make the most of the opportunity, she must not allow the moments to be idled-away, she must be creative, she must take initiative, she must search for openings into the mind and into the heart, she must have a purpose or an objective, and she must achieve it by the end of the visit. That is what is meant by controlling the situation. On the contrary, where time is spent in meaningless and idle chatter, the clock is constantly and tiresomely watched, nothing is achieved save the passing of time, then the control is in the hands of the situation.

This leads directly to the fourth observation. A visit must be given meaning. This involves preparation and conscious effort. A visit which is a formality, a hurried affair, or approached in a disinterested or slovenly manner, is not likely to achieve any purpose whatsoever. In fact, it is likely to be boring, annoying and not conducive to further visits.

The last observation is offered diffidently as it smacks of being technical. It is suggested that in respect of any intended visit to a resident, an agenda be prepared by the visitor. So that the visit should be effective, the discussion meaningful, and the time used to best advantage, it is proposed that the visitor write down items for discussion, questions to be asked on a meaningful basis, magazines flagged to draw attention to items of topical interest, newspaper cuttings produced to sustain interest, and so on. This requires time, it is, in some respects, demanding, it cannot be done on the spur of the moment, but if the resident is important enough to justify a visit, is she not also important enough, to justify a measure of preparation for a visit that will be meaningful and fulfilling?

Before proceeding with the subject of visitation and, more particularly, with the meaning of visitation, it is important to bear in mind what precisely is being discussed. In-house visitation between residents of the Ladies Christian Home (a happening which does not regularly occur) is not being considered. What is being

considered is “external” visitation, or visitation by persons who are not resident in the Ladies Christian Home.

16.2 THE MEANING OF VISITATION

To confine oneself to a dictionary definition of ‘visit’ or ‘visitation’ is to limit the whole scope and purpose of the concept. ‘Visitation’ embraces much more than ‘going to see a person as an act of friendship’ or ‘calling on a person’¹; it means more even than ‘going to see, in order to succour’ or ‘to pay call upon’²; its ambit goes wider than ‘paying a call’ or ‘making a stay’ or ‘talking or chatting’³.

Dictionary definitions are helpful as starting points but to understand the meaning of ‘visitation’ in the context of institutionalisation, one must go further and discover its essential nature in the process of visitation itself. It is not suggested that in the examination of the process of visitation a full and complete meaning can be discovered or even contemplated. Nonetheless, an attempt is made, and certain contentions are advanced.

The commencement, it is suggested, is conscious effort on the part of the visitor. An effective visitor cannot entertain negative thoughts or be negative in her approach. She must be positive. She must know what she is going to do, when she is going to do it and how she is going to do it. She must commit herself to her project and she must prepare herself for that project. Indecisive action in preparing for a visit, or executing a visit, is a sure recipe for failure in achieving a satisfactory end to the visit. Conversely, a conscious, enthusiastic effort, coupled with adequate and diligent preparation, will set the tone for a successful and happy visit.

Coupled to a conscious effort on the part of the visitor, is a caring concern for the resident. Without a caring concern for the resident, the efforts of the visitor will be without avail. It is the motivating factor, and the factor upon which all others are

¹ *The Concise Oxford Dictionary* (1951 Clarendon Press) see ‘visit’

² *Chambers English Dictionary* (W&R Chambers Ltd and Cambridge University Press 1988)

³ *The Word Book Dictionary* (Field Enterprises Educational Corporation 1975) see ‘visit’

dependent. What is being described, in reality, is love and kindly affection. This, during the early pre-institutionalisation position, was a natural and easy emotion to express. The pre-institutionalisation period is often fraught with stress and tension, and while the natural emotions are never nullified, they are often put under great strain. Likewise the post-institutionalisation period. Stress is manifested and harsh words exchanged, and while familial love is seldom lost, it is often sorely tested, and expressed with great hardship. But accepting all these stresses and strains, and accepting that the love-relationship is put under severe pressure, the blood-bond remains, a mother is still a mother, and however deeply the visitor may have to delve into her emotions, she must discover, or re-discover, the bonds of caring concern, as that is written deep into the meaning of visitation.

A further aspect which gives meaning to visitation is commitment; a commitment on the part of the visitor in relation to the resident. It may mean inconvenience, awkwardness, difficulties, and even, annoyance, but for the visitor, all these things are patiently and contentedly tolerated because she is unequivocally committed to the resident. It is a commitment which admits of no exceptions or qualifications. There may well be other commitments and other priorities but these rank after the prime commitment. Without a dedicated commitment to the resident by the visitor, visitation is lacking in an essential element.

By its very nature visitation means contact. All forms of contact, especially physical contact. Visitation means face-to-face, hand-to-hand, lips-to-lips contact; visitation means talking, conversing, joking, laughing and listening; visitation means an appropriate greetings card, a meaningful note, a bunch of flowers, a gift. Contact manifests itself in countless forms. But whatever the form, contact must be spontaneous and genuine. Where it is spontaneous and genuine, significant and purposeful visitation can result. Where it is artificial or forced, it can have a detrimental effect, the resident gaining the impression that insincerity and falsehood is at the heart of the visit.

Written deep within the meaning of visitation is communication. Communication in visitation, implies a two-way interaction, where the participants freely and willingly open their minds and hearts to each other. It is possible that, due to the condition of the resident, the visitor may, initially, have to play a dominant role in the communication process, but this process should always be aimed at active participation on the part of the resident. It is important that the resident be not treated as an inferior or as an afflicted 'old woman' but rather as an equal whose contribution to the interaction is encouraged and valued. Moreover, if the visitation is multi-partied and there is more than one visitor, care must be taken to ensure that the communication is not exchanged among themselves to the exclusion of the resident.

Contribution forms part of visitation. Contribution made by the visitor and contribution made by the resident. It is suggested that where visitation occurs without there being some contribution on either side, there is an element lacking in the visit. The visitor should consciously structure the visit so that a contribution, on her part, is made. Likewise, with the resident; that with encouragement and assistance, a contribution is elicited. At this point a warning is issued. The contribution, both ways, can be to the advantage or the disadvantage, of the other party. In this regard, attitude, ulterior motives and confrontation, can easily make their presence felt during visitation. Unless restricted and confined they can have an adverse effect on the visit so that harsh-words are exchanged and ill-will is manifested. In the result, an unfortunate and disadvantageous contribution is made, which is often very difficult to restore. In addition, it casts a damper on the next visit. It is so important that sincerity is the motivating factor in any visit and that sensibility and sensitivity should prevail.

Whatever the relationship with the resident may be, the end result of any visit should be a deepened and more meaningful companionship. Regularity is written into the meaning of visitation and with regular visits, there should be built-up a constructive enthusiasm. Moreover, as one shares more of oneself with another, and, in turn, receives the other into ones own experience, a deepened and more sincere companionship should result. This, after all, is the meaning of visitation, especially where a resident is inclined to solitude and loneliness.

16.3 THE PURPOSE OF VISITATION

There was a time when the resident was an integral part of the family, at first, the immediate family, and later, the extended family. More than that, the time arrived in the pre-institutionalisation position, when she was regarded as the Matriarch. The family circulated around and about her; she made the meals, she baked the cakes, and the birthday parties were celebrated at the family home. Then the time came for her new life and she was relocated in the institution.

First and foremost, the purpose of visitation must be to envelop the resident with love and embrace her again into the family. True, many things have changed, not the least of which is that the family home and the time-honoured furniture is no longer there. But she is still there, and she is still (or must be made to feel that she is still) the Matriarch. What has changed? The Patriarch is dead, the family has grown-up, the grandchildren (and the great-grandchildren) have been born, and the passage of the years has taken its toll. What was a human dynamo, has now slowed down; what was the family-manager, has now become forgetful; and what was the life of the party, now sits quietly, by herself, in the corner of her room. For the rest, nothing has changed. And she must be reminded of this. If she can no longer understand and appreciate words, she must be shown love and affection; she must never be an embarrassment; and she must never be forgotten. She always was, and always will be, the centre of the family.

Secondly, though the mind may be imperfect and play tricks, memories of the past must be revived and rekindled. This requires time and effort. The visitor must constantly prepare lists (with the help of the family) of family memories or long-forgotten events. It may require the assistance of relatives or family friends, it may require searching for old photographs, it may mean time and trouble, but the revival of old memories will bring much joy. Of course, it may now be too late, and the dementia of old-age may blot out the past. But what can still be done, must be done, for that is one of the purposes of visitation.

When one is young all of life is ahead; plans to be made, things to be done; places to be visited. What happens when one is old? What lies ahead? Does it help to make plans? What things have not been done, must now be left undone, what places have not been visited, must now be left unvisited. Is there any reason to live? One of the purposes of visitation is to give the resident a reason to live. The sun still shines, the flowers still bloom, and the date of death has not yet arrived. If, for the resident, little of life is left, she must be encouraged to live in the lives and experiences of others (her children and grandchildren). If she can no longer plan for the future, then let her share in the future plans of others. If she can no longer do things, then let those who have things to do, share them with the resident. If it is impossible for her to visit places strange and exotic, then let her do it with those who still can. The day of the memorial service will come. Until then, let her have reason to live.

Does it make any difference how she looks? After all she is old. The reason for visiting her is to improve her self-esteem. Let her have her hair done, and tell her how nice it looks. Make up her face, and tell her how pretty she looks (indeed, let her look into the mirror and see how she looks). It is easy to reprimand her and become angry at the state of her dress. Change her dress, and tell her how good it looks!

The thought patterns of some ninety-year-olds are positive and constructive, and these thought patterns motivate and inspire an active style of conduct. They are always on the go, helping others, shopping for others, visiting others. They look forward to outings with the family, they plan for celebratory functions, and they write letters to old friends. Others are singularly unmotivated, and are far from active in their lifestyle. They sit and waste away the hours. What precisely are their thought patterns are difficult to determine; what is certain is that they have no forward look, they make no plans, and they engage in no constructive conduct. One wonders if, apart from breathing, they have not already died. How does the visitor deal with such a resident? Firstly, the visitor must be sure to impart positive encouragement. Secondly, she must import into the situation a spirit of hope. And

thirdly, the visitor must introduce a vision for the future. Although the past plays a dominant role in the experience of many residents, they cannot live entirely in the past. They must have something for which to struggle and to strive, something for which to look forward, something which the future holds. The occupational therapist provides an interesting, constructive and creative programme; the Rotary Anns and Lions Club offer varied and interesting outings; other clubs and organisations arrange entertainments. The resident must not only be encouraged to participate, but the visitor should peruse the programmes with her, plan her future, give her something for which to look forward, and, if the occasion provides, participate with her in certain activities. This does not just happen. It must be made to happen by encouragement, giving a spirit of hope, enlarging the scope of the resident's vision. This is the purpose of visitation.

Boredom comes easily. The visitor must obviate it. This is the purpose of visitation. One means of obviating boredom is for the visitor to entertain the resident. In other words, to keep her mind occupied and her body busy. To play cards with the resident, or scrabble requires preparation on the part of the visitor and application on the part of the resident. But it is a sure means of obviating boredom. A simple game of rummy (even if the visitor must offer assistance to the resident) is a way of engaging the resident in thoughtful activity. It may also provide a means of including others. Another means of obviating boredom is for the visitor to amuse the resident, to make her laugh and incorporate a spirit of happiness. Boredom can be depressing and it is important for the visitor to raise the spirit of the resident. Enlightenment too, can obviate boredom. To page through a newspaper or popular magazine and highlight events of interest can go a far way to rekindle curiosity in what is happening in the world. It leads to an exchange of conversation, questions are asked, and information is imparted that can be passed on to other residents.

Where effort and preparation is put into visitation, the invariable result is that the relationship is built-up and strengthened, conversation and discussion is increased, and needs (and complaints) are made known. The visitor must not avoid these issues or be embarrassed by them. It is the purpose of visitation to meet the resident at her point of need. But this can only be done if the need is known, and the need can only be known if the resident is confident enough, and comfortable enough, to speak to the visitor, and engage in meaningful conversation.

The visitor must be careful not to overwhelm or distress the resident. She is not there to preach, proclaim or pontificate. The purpose of visitation is for the visitor to draw alongside the resident, to companion with her, to share in her joys and her sorrows, to offer succour and comfort in times of distress and anxiety, and to meet with her at her point of need. The situation may well justify the retort, "I told you so", it may even justify a stern reprimand, but the visitor must contain herself. The resident, it must be remembered, (despite manifesting a strong and bold front) is sensitive, defenceless, and, often, weak. To overwhelm or distress her will serve no good purpose. It will build up barriers and raise defences; it will put parties in opposite camps; and the resident will be inclined to retire into her shell.

Nor must the visitor try to prove a point or win an argument. This is not the purpose of visitation. It is not suggested that the resident is always right; that she is blameless in the things she says; that she is faultless in conduct and attitude. It is not suggested that the resident is never the author of situations which justify reprimand on the part of the visitor, or opens the way to justifiable argument. All this is conceded. What is suggested is that no good purpose will be served by the visitor trying to prove her point or win her argument.

This leads to the penultimate purpose of visitation. After all is said and done; after the most diligent analysis has been concluded as to what the purpose of visitation is; and after each and every aspect has been debated and discussed, the ultimate purpose of visitation is to listen to the resident. It may be "the same old story", it may be "the same old complaint", it may be "the same old moan", but in the end, if the visitor is able just to listen, then more will be achieved than the most justified of reprimands or the most skilful of arguments.

Lastly, the purpose of the visitation can be summed up in the admonition "don't disappoint". A visitor can disappoint in the frequency of visits, in the duration of visits, and the quality of visits. A resident will defend a relative visitor to the utmost where there has been disappointment in visitation, especially where there has been a failure to visit. But there is little doubt that deep disappointment is felt.

16.4 CONCLUSION

The meaning and purpose of visitation have been investigated as part of an extensive investigation into the matter of visitation. The need for visitation is now examined.

Chapter 17. THE NEED FOR VISITATION

17.1 INTRODUCTION

Visitation is a central theme of this investigation. Its validity lies in the need for visitation. If there is no need then there is little point in the investigation. If there is a need, that need stands to be investigated and analysed. The contention will be advanced that there is not only need for visitation from a general point of view, but there is need for visitation from a 'specialised' point of view. To come to terms with the need for visitation, it is needful, primarily, to understand and appreciate the role of institutionalisation as it relates to and results in the isolation of the resident. These matters, together with other matters, will be considered and examined. Certain preliminary observations stand to be made.

The effect of institutionalisation is to introduce the individual to the crowd. At the same time, the investigation will reveal, the isolation of the resident, in many instances, is a fact of life. In other words, institutionalisation does give rise to isolation. The resident, as an act of volition, chooses the isolation of her room. Not that it is her choice to be alone, or lonely. Indeed it is not. But she, nonetheless, seems to prefer the solitude of her room. She longs for contact and for visitation. Her door is open, despite her election not to join the crowd. Moreover, she remains part of the family and members of the family are welcome. So is the 'specialised visitor'.

This is a strange contradiction. On the one hand, there is the potential to be one of a group. On the other hand, isolation is preferred. On the one hand, there is a longing for visitation. On the other hand, no (or little) attempt is made to visit others. It may be that generalised contact is not preferred, and that 'idle chatter' is to be avoided. What is more desirable, is 'targeted visitation', that is, family, friends or 'specialised visitor' visiting the resident especially.

17.2 INSTITUTIONALISATION

It is not proposed to revisit the subject in general terms¹. The purpose, rather, is to examine it against the background of the need for visitation. The first observation to be made is that one of the effects of the institutionalisation process is to remove the resident from the immediate vicinity of her family. The contact which, formerly, was direct, spontaneous and immediate, has become infrequent, limited and coercive. It is not intended to derogate from the good work done by the institution. The only purpose is to indicate that the process of institutionalisation gives rise to a need for visitation.

The second observation is that the process of institutionalisation separates the resident from her support system. Friends and family who previously surrounded the resident and supported her in the ordinary, normal process of living are no longer there. She is alone. They meant so much to her and their support was so valued. Now, alone, she must live her life within the context of the institution and according to its rules.

The third observation is that institutionalisation removes from the resident her independence. Differently put, the institution assumes the independence that was previously possessed by the resident. Before, she could do as she pleased, she could come and go as she pleased, she could associate with whom she pleased, and when she pleased. Now, she was dependent upon others. Dependent upon others to keep her in touch with the outside world.

The last observation relates to her contact with others. This, by choice, is limited. She can communicate with other residents, but for some reason, she is reluctant so to do. She longs for her family and friends. She wants to be visited, regularly and often.

¹ See Chapter Ten : *The Resident : The Nature and Effect of the Process of Institutionalisation*

17.3 INCORPORATION

Incorporation means the gathering together of isolated entities and combining them into a single united body. It is the opposite of dividing the whole and separating and isolating the individual parts. One might expect incorporation, or gathering together of isolated residents and combining them into a single united body, to be the means of according to a resident that self-assurance, self-dependence and self-sufficiency to obviate the need for visitation, at least, on a regular and continuous basis. Incorporation occurs. The resident becomes part of the group and she is surrounded by people. There are comfortable lounges where residents can meet and socialise with residents. There is a communal hall with a large-screen television. Residents share meals with residents, they engage in shared times of worship (after which tea and refreshments are often served), there are group exercises, and group entertainment.

Incorporation does not yield the desired effect. After each and every group activity (of whatever size) there comes a dividing of the whole, a separation of resident from resident, and an isolation of the individual parts. It is a rare instance when a resident's room is found to be unoccupied. The distinct impression is created that a resident seeks solitude to await visitation.

Incorporation does meet a need but it is not a substitute for visitation.

17.4 INTRENCHMENT

Intrenchment (entrenchment) is defined as being surrounded with a trench². One wonders if this is not an effect of institutionalisation. In military terms, a trench is a deep ditch which is dug by troops to shelter them from the bombardment of the

² *The Concise Oxford Dictionary*

enemy. It may also be likened to a moat or defensive ditch surrounding a castle or a town. The suggestion that is being conveyed that, on two fronts, the resident becomes 'dug into' a situation.

The first front is that of the institution providing a ditch behind which the resident can find safety and security. The second front is that of the room which provides a ditch behind which the resident shields herself. At the same time, she retreats into a solitude from which it is difficult for her to escape. Her only mode of escape is to open herself to visitation. This is not the enemy. She can safely drop her defences, and there is no danger in exposing herself.

The analogy must not be misunderstood. It is not suggested that institutionalisation gives rise to incarceration; that the resident, in fact, becomes a prisoner in a gaol from which there is no escape. What is suggested is no more than that the resident adopts an attitude or state of mind, the effect whereof is isolation; an isolation which is only relieved by visitation.

17.5 ISOLATION

Isolation implies detachment, insularity, separation and dissociation. It manifests itself in the form of a resident alone in her room. It reveals itself in the figure of a resident who is an integral part of a group but at the same time is isolated. Notionally, she became isolated by the process of institutionalisation. Physically, she became isolated by leaving the group and withdrawing to her room. Emotionally, she became isolated by emerging herself into her own thoughts, feelings and private problems. Isolation has its place in the scheme of things but when it becomes a pattern of life, it is to be discouraged. There is nobody with whom to communicate, nobody with whom to share, nobody to help you. It is at this point that the need for visitation becomes most obvious. When you are alone with

yourself, your thoughts, your emotions, your personal needs that the intervention of a third person is vital. Moreover, the person most likely to intervene, because of his availability, is the 'specialised visitor'. But whether it be the 'specialised visitor' or some other person, the fact of the matter is that the need exists, and in terms of a quality of life, must be met.

17.6 INDIVIDUALISATION

The need for visitation is further demonstrated by the process of individualisation, that is, to give an individual character to a resident. Whatever may have been the initiatory or supportive role played by the family in the process of institutionalisation, there comes the point in time when those roles (albeit temporally) cease and the resident stands alone. She becomes a member of a particular class of resident; she becomes the occupant of a particular room; she becomes a unit of the administration; she becomes a feature on the list of pensioners. If she goes out, she must sign the book; if she returns to the Home, she must sign in again. If there is something defective in her room, she must record the defect in the appropriate book, and await action. She is recognised as an individual, and she stands on her own. Whereas before, there was always someone to whom to turn, now she has to deal with the query or the problem.

This marks a need for visitation. The need for someone to draw alongside and companion with the resident; someone to confirm that what has been done was the correct action; someone to indicate where the diningroom is situated; someone to suggest that the problem justified an approach to the General Manager or the Bursar. These are days filled with problems and, often, they are lonely days.

Who is there to help? Members of the family visit from time to time but somehow nobody is on hand at the critical moment. The administration is always there but

whether they ought to be approached or not, is a problem in itself. Sometimes, what appears as a trifling matter causes great consternation and is needful of assistance. With the passage of time, matters sometimes become easier, at other times, they become more difficult. What is needed, is someone on hand, to offer succour and assistance. What is needed, is a visitor, in the person of 'a specialised visitor'.

17.7 CONCLUSION

However sensitive is the process of institutionalisation, and however careful is the process of the incorporation of the resident into the body of the Home, intrenchment and isolation present themselves as very real problems. And with intrenchment and isolation, comes the need for visitation, and especially 'specialised visitation'. The question arises as to what the defects and shortcomings (if any) of the normal or regular pattern of visitation are? It is to this aspect of visitation that attention is now directed.

Chapter 18. THE NORMAL OR REGULAR PATTERN OF VISITATION

18.1 INTRODUCTION

Visitation does occur. Visits to residents by members of the family and friends do take place from time to time. No two visits are identical but similarities do emerge and patterns of conduct can be detected. The question that arises is whether there is a normal or regular pattern of visitation, and if so, of what does it comprise? How often does it occur and who are the participants in such acts of visitation? It must always be borne in mind that the central feature of any act of visitation is contact and communication with the resident. The investigation, therefore, embraces the matter of participation in the visit, that is, whether it effectively and comprehensively includes the resident or whether, in fact, it bypasses the resident? This incorporates the very object of the visit. What must be faced is whether the visit is no more than the exercise of a habit or customary practice, or whether it is directed at an improvement in the quality of life of the resident. This necessitates an investigation into the control of the act of visitation and the regularity thereof. It also incorporates the prospect that far from improving the quality of life of the resident, it introduces confrontation, crisis and upset in the life of the resident.

An answer to these and other questions will be attempted on the supposition that the investigation will reveal a 'normal or regular pattern' of visitation, which falls short of what is required to enhance, effectively, the quality of life of the resident. The argument will be advanced that what is required to enhance the quality of life of the resident, is the introduction of a programme of 'specialised visitation'.

18.2 PATTERN OF VISITATION

The investigation took place over a period in excess of two years. It occurred on four mornings a week and involved several thousand acts of visitation. Inquiries

were also instituted into visitational activities which happened during afternoons, evenings and week-ends. The outcome of this research, generally speaking, is four-fold. Firstly, visits during weekdays do occur but their impact is so minimal that it can be disregarded. They are largely limited to daughters of the resident who call at fixed and regular intervals during the week, and sons who will make fixed or spontaneous visits during the week, usually after work. Secondly, visits over the week-end are more popular than visits during the week. But they apply to a relatively small group of visitors who are fixed and regular in their week-end visits. Thirdly, it does happen that, either regularly or from time to time, family members take the resident out i.e. away from the Home, either for a day-visit, or an overnight-visit, a week-end visit, or for a longer period of time. It should be mentioned that these outings are not wide-spread and are usually limited to the same group of residents. Fourthly, and this applies to the majority, visitation does not take place at all, or if it does, it is very occasional and very irregular.

It must be added that those who do not receive visitors are fiercely defensive of members of the family who could pay them a visit but do not. They offer all manner of excuses as to why they are not visited. Either the family is too busy or are otherwise engaged but no blame or condemnation is ever levelled at the family. It is emphasised that this is not an isolated occurrence but takes place without exception.

After every observation that can be made concerning a pattern of visitation, has been made, the fact remains that the situation concerning the visitation of residents is far from satisfactory and is distinctly disturbing when regard is had to the resident's need for visitation¹.

18.3 OCCURRENCES OF VISITATION

If one is permitted the luxury of generalisation and assessment, it may generously be said that twenty-five of the one hundred and twenty residents receive a visit (on a

¹ See Chapter Seventeen : *Visitation : the Need*

regular basis) once a week. Five or six receive a visit more than once a week and ten or twelve members of a family will make themselves available on short notice, and on good reasons being advanced.

The argument in favour of 'specialised visitation' which is being advanced, encourages visitation which is regular and continuous. This is a far cry from what is actually happening. If one accepts the effects of institutionalisation, and the occurrence of intrenchment, isolation and individualisation², and if one accepts that the resident is engaged in the process of living (not dying) with all the problems attendant thereupon, then one must accept that the situation relating to the visitation of the aged, is less than satisfactory and stands to be improved.

18.4 PARTICIPANTS IN VISITATION

When one considers the pattern relating to those who participate in acts of visitation, the position does not improve. Again, one must resort to generalisations, and readily agree that such generalisations do admit of exceptions. Invariably, it is the daughter (or daughters) who visits the mother. Sometimes, the son puts in an appearance, which may be on a regular basis, but will more likely be, irregularly. Other members of the family (including grandchildren) do visit from time to time, particularly on special occasions such as a birthday. This is definitely an exception to the general rule.

Still more of an exception are visits by old family friends. There is an obvious reason for this omission. When one has regard to the age and physical or mental condition of the resident, it is unlikely that there are many old family friends who are able to visit the resident. But they do exist, and they can make a handsome contribution to the resident.

² See Chapter Seventeen : *Visitation : the Need*

18.5 SHARING IN VISITATION

Sharing in the act of visitation gives rise to problems. The motivator and initiator of the visit is the visitor. Moreover, it is the visitor who has the most to contribute from the point of view of intellectual capacity, physical ability, and knowledge of the outside world. Accordingly, it is the visitor who assumes control of the situation³ and tends to dominate the visit. It is she who has the most to say with little or no regard to what the resident may have to talk about. Little effort is made to elicit comment from the resident, and in particular, to ascertain whether she has problems or difficulties that she wishes to discuss.

The problem is often exacerbated by the presence of other parties, who, in turn, feel compelled to talk, either to the resident or to the visitor. Indeed, the visit sometimes turns out to be a conversation between the visitor and the third party, with little regard being had to the resident. Sight is lost of the fact that central to the visit is the resident. Moreover, little thought is given to quiet contemplation.

18.6 FORMAT OF VISITATION

Save in one respect, little thought or consideration is given to the format of the visit. The one exception relates to the matter of talking, which, invariably, forms the principal component of the visit. This is particularly taxing where the resident is hard-of-hearing or has some form of dementia. Moreover, the investigation reveals that there is little or no inclination on the part of the visitor to prepare for a visit or to use imagination in the form the visit should take.

Occasionally, a visitor will take a resident for a walk in the garden, or just sit in the garden and admire the beauty. But never has it been observed that a visitor will take a resident through a magazine or a newspaper. Still less does it occur to the visitor that the resident (where capable) may enjoy a game of cards or scrabble.

³ See Below : *Control of Visitation*

The normal or regular pattern is for the visitor to talk (and to dominate the talking) and perhaps, where facilities permit, to drink tea.

18.7 DURATION OF VISITATION

More often than not, a visit is one of two kinds, namely, “an-in-and-out” or a visit of some depth (the duration of which depends upon the condition of the resident). It is surprising how impatient a visitor can be; the sooner she can get out of the place, the better. It may be that the resident lacks the ability to stimulate the visitor, or to provide pleasurable entertainment. But whatever the reason, the visitor has no sooner arrived, than she feels compelled to leave.

The other sort is more tolerant and patient. So much so, that she wears out the resident. What is required, essentially, is not duration of time, but a quality of time. That is to say that time is well-spent in listening to the resident; giving her time to express her views or her problems (or her complaints); and patiently and kindly giving her advice and guidance.

18.8 OBJECT OF VISITATION

At some time or another the question must be asked: What is the object of the visit? Is it part of a customary ritual or habitual practice? Does it, at any time, enter the mind of the visitor that the purpose of the visit is to improve the quality of life of the resident? Does it occur to her (the visitor) that the resident may want to embark upon a discussion concerning a matter that is troubling her? Does the visitor see the resident as a personality harbouring emotions and problems, and engaged in the process of living?

These are all relevant questions to which few visitors give their attention. Indeed, it is suggested that in many visitations, no thought whatsoever is given to the object of the visit.

Unless the resident is constantly seen as a person with a quality of life that stands to be improved by the act of visitation, the object of the visit is of little avail.

18.9 CONTROL OF VISITATION

A visit must be controlled. This does not mean dominated by one or other party. It means control so that it has direction, purpose and an objective. Control does not imply a rigid regimentation as though a visit was a precise military manoeuvre. This would be contrary to the very nature of visitation which is characterised by tenderness, gentleness, kindness and love. Control gives substance and meaning to a visit, so that an intended objective is achieved, and that the visit proves to be a worthwhile achievement. More often than not, the normal or regular visit has no form and is allowed to drift, so that the time spent with the resident is wasted and no positive purpose or result is accomplished.

Mere control does not satisfy the requirement. What is required is constructive control. Constructive control seeks to steer the contribution made by each participant in a direction which will lead to the ultimate benefit of the resident and, at the same time, provide each participant with a feeling of goodwill and satisfaction at what was achieved at the visit.

Constructive control will, in all probability, be provided by the visitor. But this requires preparation and forethought as well as restraint, lest the visitor should dominate the proceedings. At the same time, it is not inconceivable that the resident may endeavour to exercise control of the visit, especially if there is much about which to complain, or her state of health is such that it leads to endless comment. This form of control need not necessarily be stifled but constructive control must be exercised so that a desirable end to the visit may be achieved. Sensitivity must be employed to determine whether in the midst of the complaints, or adverse comments, some meaningful message is not, in fact, being conveyed.

It is suggested that visitation according to the normal or regular pattern without a fairly large measure of constructive control, will not achieve the desired purpose or end.

18.10 CRISIS IN VISITATION

It is not suggested that every visit, whether frequent or not, is a model of cordiality and affection. Indeed, visitation according to the normal or regular pattern, often manifests itself in confrontation, arguments and angry exchanges. Not infrequently, this leads to harsh words being spoken, relationships strained to breaking point, anguish and heartache.

Crisis in visitation can only lead to some form of upset which is deeply regretted thereafter. It must be avoided at all costs. At the same time it usually turns on the question as to who is right and who is wrong on a particular point. In the end, it is usually irrelevant as to who is wrong on a particular point. But it often leads to a cessation (at least for a while) of the visitation pattern. It is not suggested that the resident is always right and the visitor is always wrong. What is suggested is that it is easier for confrontation to be avoided than to make up after an upsetting outburst. Expedience and sensitivity must be exercised at all times and it must always be remembered that the resident has lived for a long time, and the likelihood of getting her to change her ways at this stage of life is remote indeed.

18.11 REGULARITY IN VISITATION

How often must a resident be visited? Once a week, twice a week, once a month, every now and again? It is difficult to lay down a rule which is hard and fast. Much depends on the prevailing circumstances. The demands of business, the distance from the Home, the availability of transport, the relationship with the resident, family circumstances, are all factors to be taken into account.

Certain facts are incontrovertible. The resident is old; in some cases, she is unwell. She is alive but her length of days is uncertain. In certain cases she has the power to reason but this may disappear. Some day she will die. Visitation, then, is no longer possible. She may have something to say, she may wish to communicate, she may harbour a problem, she may be disturbed emotionally and wish to speak to someone.

To whom must she speak, and who will speak to her? What is the pattern of normal or regular visitation?

18.12 CONCLUSION

The normal or regular pattern of visitation has been analysed and examined. In a number of respects it fails in its objective to improve the quality of life of the resident. Is there an alternative? It is suggested that there is. This alternative lies in a specialised pattern of visitation and it is to this subject that attention is now directed.

Chapter 19. THE SPECIALISED PATTERN OF VISITATION

19.1 INTRODUCTION

The observation has been made that the prevalent mode of visitation of the institutionalised aged is in accordance with the normal or regular pattern¹. This means that the vast majority of residents receive only occasional and irregular visits from family and friends, while it is the minority who receive fixed and regular visits on more than one occasion during a particular week². Moreover, it is this small minority who receive visitation of a nature which is conducive to an enhanced quality of life³.

Two questions arise. The first is: is it right that this state of affairs must be allowed to persist? And secondly: can anything be done about it, that is, is there some alternative to the normal or regular pattern of visitation, whereby the quality of life of the institutionalised aged can be enhanced and improved?

The answer to the first question is an emphatic no: the state of affairs must not be allowed to persist. The answer to the second question is that something can be done about it and that there is an alternative to the normal or regular pattern of visitation, the result whereof is an improved and enhanced quality of life of the institutionalised aged. The answer lies, it is submitted, in 'specialised visitation' which is something different from ordinary, normal, social visitation. It is a form of visitation which is more intense, more concentrated and more regular. Moreover, it is directed at an improved quality of life of the aged and holds out benefits and advantages for them.

¹ See Chapter Eighteen : Visitation : The Normal or Regular Pattern

² See Chapter Eighteen : Pattern of Visitation

³ See Chapter Eighteen : Occurrences of Visitation

19.2 THE 'SPECIAL' NATURE OF SPECIALISED VISITATION

The 'special' nature of specialised visitation lies in the fact that it is visitation of a particular kind, it is distinct from other modes of visitation; it is not visitation in the general sense. It is more than ordinary; it is unusual; it is exceptional.⁴ It possesses attributes which distinguishes it from the normal or regular pattern of visitation.

There are several reasons as to why the alternative to the normal or regular pattern of visitation is described as 'special'. First and foremost there is the matter of relationships. The normal or regular pattern of visitation is based upon a familial relationship which is predetermined and immutable. Specialised visitation has nothing to do with family, or birth, or parentage, or descent. It is based upon a special relationship; a relationship which has grown, developed, evolved, enlarged and expanded through regular and continuous contact and communication. It is a relationship which has emerged over a period of time by the manifestation of interest, concern and a caring regard for the resident by the specialised visitor. It is a relationship based upon mutual trust and confidence shared between the resident and the specialised visitor.

Secondly, there is the matter of duty. Whatever the actual relationship between the resident and the family, the blood-relationship imposes certain duties upon the family in regard to the matter of visitation of the resident. The discharge of this duty varies from family to family and from resident to resident. It can vary from regular and frequent visits to occasional and irregular visits.⁵ Specialised visitation has nothing to do with duty. No obligation to visit a resident is imposed upon the specialised visitor. His desire to visit a resident arises out of a caring concern for that resident and an interest in her health and welfare.

⁴ *The World Book Dictionary* : See 'special'

⁵ See Chapter Eighteen : Pattern of Visitation

Actually, it is more than all of this. With the passage of time, there has been built up between the resident and the specialised visitor a friendship and a confidence which motivates him to spend time with her, to talk to her, to listen to her, and to encourage her.

Thirdly, there is the matter of regularity. It has been observed that with the normal or regular pattern of visitation, the regularity with which visitation takes place varies considerably.⁶ In certain instances, it does not occur at all. This is not so with specialised visitation. Here, convenience or inconvenience on the part of the visitor, does not play a role. What plays the cardinal role is the condition and circumstances of the resident. Where the resident is ill or ailing, or where she is in need of succour or support, the specialised visitor is available for visitation. It may mean a visit on every day, it may even mean more than one visit on a day but regularity is not fixed and determined. This is what makes the pattern of visitation special.

Fourthly, there is the matter of an objective. Certain observations have been made in this regard.⁷ The suggestion is made that in respect of many visitations, no thought is given to the objective of the visit. And the question is posed as to whether it is not part of a customary ritual or habitual practice. There may well be merit in both these suggestions but neither is valid when it comes to the matter of specialised visitation. Here, there is no suggestion of ritual or habit. Nor is there any suggestion of a visit lacking in objective. Each and every visit is carefully planned. The circumstances relating to every resident is carefully considered. The resident is neither a member of the family, nor a statistic; the resident is visited as a person engaged in the process of living. The process may be limited, tiresome and arduous. But the visitation is special, and directed at the prime objective of making that process worthwhile.

⁶ See Chapter Eighteen : *Pattern of Visitation*

⁷ See Chapter Eighteen : *Object of Visitation*

Fifthly, there is the matter of motive. There are various factors which motivate a person to visit a resident in accordance with the normal or regular pattern of visitation. One factor is the familial relationship which exists between the visitor and the resident. Another factor is the sense of duty which is owed by the visitor to the resident. There are, no doubt, other factors. With specialised visitation, however, there is no question of any blood-relationship, nor any sense of duty which is owed by the specialised visitor to the resident. This is what makes the pattern of visitation special. The motivating factor in specialised visitation is the sense of calling of the specialised visitor; his caring concern for the welfare of the resident; and his desire to see the quality of life of the resident improved and enhanced.

Lastly, there are the matters of independence and influence. It is not true to say that the specialised visitor is completely independent, but he does enjoy a very large degree of independence. He is answerable to the Board of Trustees and he does work in collaboration with the administration. But whom he visits, and when he visits, and what he discusses in the course of visitation, is very much his own business. He is recognised and accepted as an independent operator. The confidence he engenders, and the matters he deliberates, are based on the unfettered independence of the specialised visitor. Moreover, he is recognised and accepted as a person who has influence with the Board of Trustees, the administration and the employees. This imbues the pattern of specialised visitation with a 'special' nature. He is entrusted with confidences that are not shared with visitors who accord with the normal or regular pattern of visitation.

19.3 THE SPECIALISED PATTERN

The original plan was that the specialised visitor would confine his visits to those residents occupying the 'front part of the Home', that is to say, to those who were more mobile, more physically able, and more intellectually capable than those who resided in the 'back part of the Home', or the Frail Care Wing.⁸

⁸ See Chapter Two : *The Nature of the Investigation*

And indeed, this is where the specialised pattern of visitation was initiated, devised and developed.

With the passage of time, however, a number of those residents who occupied the 'front part of the Home' became weaker and frailer and were transferred to the Frail Care Wing. In the meantime, the specialised pattern of visitation had become established and those who previously had been part of the programme wanted it to continue even though they had become part of the Frail Care Wing. The programme was accordingly extended to embrace those who had formerly been visited but were now in the Frail Care Wing. The specialised pattern, in consequence, operated in four parts of the Home.

The first part is in the 'front part of the Home' on the ground floor and comprises approximately twenty beds. The second part is in the 'front part of the Home' on the first floor and comprises approximately thirty-eight beds. The third part is in the 'front part of the Home' on the second floor and comprises approximately twenty-seven beds. The fourth part is in the Frail Care Wing situated on the ground and first floors and comprises (as at the beginning of the year 2000) approximately twenty residents.

The name and room number of each resident is recorded on a chart and a monthly record is kept of each visit to each resident. A copy of a monthly chart is annexed.

19.4 OCCURRENCES OF VISITATION

The monthly chart is a key factor. To the right of each name of a resident are eight blocks. In each block a tick is recorded for each visit to a resident. Visitation occurs on four days of each week from 0900 to 1300. Potentially, therefore, provision is made for eight visits a month, or, two visits during each and every week, or one visit on every second day.

The distinguishing features of the visitation programme are regularity and continuity. Constancy. It is not intended to suggest that the monthly chart is pursued with mathematical precision. As will presently be seen, the circumstances surrounding a particular resident may be such as to demand daily visits, or even, more than one visit a day. What is sought to be avoided are gaps in the programme and prolonged intervals.

19.5 REGULARITY OF VISITATION

If regularity, continuity and constancy are the prime characteristics of the visitation programme, one would expect that a systematic and orderly working through the monthly chart, according to a rigid timetable, would produce the desired result. The object of the exercise, however, is visitation, not a statistical return. It is to get to know and understand people, it is to minister to them at their point of need, it is to offer encouragement, succour, and an enhanced quality of life. Accordingly, the regularity of visitation must be flexible and appropriate to the condition of the resident and the circumstances in which she finds herself.

This could mean that it is necessary to spend more time with one resident than with another; it could also mean that it is necessary to visit one resident more often than another. As significant as time may be, it must not be allowed to blur the objective of the visit. The allotted time of a visit may be so long but the resident may want to serve coffee, and this may be an event of some significance. The allotted time must yield to the drinking of coffee, however long it takes.

The watchword, however, must be regular and continuous contact. Whether the visit is fleeting or of lengthy duration the monthly chart must be covered, and the specialised visitor must become a pleasurable part of the life of the resident whose visits are something to which she looks forward.

19.6 FORMAT OF VISITATION

No hard-and-fast rule can be laid down as to the format that an act of visitation should take. It obviously depends upon the resident and the surrounding circumstances. A meaningful visit can be accomplished with the exchange of a few words; indeed, it can be accomplished in complete silence. Where the resident is in a state of extreme upset, or is *in extremis*, or in a state of senile dementia, a quiet holding of hand, or a stroking of a cheek, can accomplish more than a 'mouthful of eloquent words'. Each situation must be carefully assessed, and wisdom must dictate the format of the visit.

Regular and continuous contact linked to studious and attentive observation of the resident can convey a meaningful message. It frequently conveys the state of health of the resident, and often, her state of mind. This gives an opportunity to the specialised visitor to embark upon meaningful discussion with the resident, the end result of which may be an improved state of mind or health. It could also lead to emotional problems which need to be expressed, initially, perhaps, to the specialised visitor, and thereafter (perhaps), to someone else.

The format of any visit depends upon a number of factors. Certainly, it depends on regular and continuous contact; it depends upon attentive observation; it depends upon discernment; it depends upon wisdom. The specialised visitor must be sensitive and alert. He must not impose himself when he is not wanted, and he must not be hurried when he is wanted. Moreover, he cannot plan the format of a visit in advance; he must be sharp of mind and possess the necessary skills to know how to conduct himself in any particular situation.

19.7 DURATION OF VISITATION

The success of a visit is never determined by its length or brevity; its success lies in its effectiveness. The specialised visitor, after a visit, may well stop and ask himself: what, if anything, has been achieved by the visit? This is the ultimate test.

Rarely is it that nothing is achieved by a visit. There are very few old people (although some do exist) who do not want to be visited by somebody. But this also is not the test. Merely to please a resident by one's presence is not the be-all-and-end-all of specialised visitation. This does not mean to say that such a visit is without avail, provided effective contact and communication with the resident has been made.

Indeed, the duration of a visit should be, at least, as long as it takes to make effective and meaningful contact with the resident. Moreover, within the ambit of reasonableness, it should not be terminated while effective and meaningful contact continues. This means that cogent and significant contact may be made during a comparatively short visit, while little may be achieved during a more lengthy visit. The duration of a visit must be measured in terms of the quality of the contact and communication that is enjoyed with a resident.

19.8 OBJECT OF VISITATION

A visit must never be haphazard or aimless. It must always have an objective. That objective need not necessarily be grave; it may be little more than a meaningful greeting but the specialised visitor must be astute to vary his objective where an opportunity for deeper and more serious communication presents itself. And this comes with the passage of time, as the specialised visitor and resident come to know each other better; come to trust each other; and come to realise that the object of the visit is more than exchange of frivolities or trivialities.

The ultimate objective must always be borne in mind. It is to improve and enhance the resident's quality of life. It is to meet the resident at her point of need. It is to help her resolve her problems and difficulties. It is to draw alongside her and share with her any burdens she may bear. It is to build up a relationship in terms whereof the resident can trust the specialised visitor and discuss with him any disturbances she may harbour.

Care must be taken not to place the cart before the horse. Trust takes time, and the specialised visitor must bide a while before he can expect a resident to share with him her inner thoughts and emotions. But this point will be reached only through regularity and continuity of planned and programmed visitation.

19.9 CONFIDENCE AND CONFIDENTIALITY

The confidence under discussion is the confidence placed by the resident in the specialised visitor. This means a firm trust or belief on the part of the resident in the specialised visitor, and an assurance that the specialised visitor will not tell others what is said.⁹ This is a right which has to be earned, and moreover, it is not earned overnight. It comes about by regular and continuous visitation over many months, even years. It arises out of a relationship built-up between the resident and the specialised visitor as a result of contact between the parties, communication, good faith and credence.

It is the natural and obvious consequence of the specialised visitation programme. It cannot be accomplished by sporadic or intermittent visits. The resident, through the visitation programme, can detect a genuine concern for her personal welfare, and an honest interest in her quality of life and her surrounding circumstances. Uppermost in her mind is the thought that in the specialised visitor is 'on her side' and that she can safely put her confidence in him.

19.10 CONCLUSION

The pattern of specialised visitation has been examined and analysed. Its 'special' nature has been carefully scrutinised as well as other notable characteristics. If the pattern of specialised visitation is what it is argued to be, then it must hold out benefits and advantages for residents. It is to this subject that attention is now directed.

⁹ *Chambers's Twentieth Century Dictionary* (W.&R. Chambers Ltd 1966); *World Book Dictionary* (Field Enterprises Educational Corporation 1975)

Chapter 20. THE BENEFITS AND ADVANTAGES OF VISITATION

20.1 INTRODUCTION

The question that stands to be answered is whether specialised visitation holds out any benefits and advantages to the institutionalised resident. One must never lose sight of the central issue. The passage of time, invariably, has a detrimental effect on the physical state of the resident; in many cases, on the mental state too. In the final result, the investigation is concerned with the quality of life of the resident and what can be done to improve such quality of life. Where the care of the aged is not purposefully linked to an improved quality of life, then sight of the central issue is lost. Such being the case, it must hold out benefits and advantages. What then are the benefits and advantages, and how is the quality of life improved?

Observations have already been made, concerning the need for visitation.¹ The facts and circumstances giving rise to visitation will be examined in the next chapter.² It is not proposed to canvas the same subjects. The subject-matter dealt with in this chapter, is confined to the benefits and advantages of specialised visitation viewed in isolation.

20.2 CONTINUITY AND REGULARITY

The arrival of old age does not mean the departure of personality or humanity or self-esteem. Whatever the age of a resident maybe, she remains a person, a human-being, and an individual. However weak she may be physically, or however feeble she may be mentally, or however confused she may be emotionally, she is still somebody. But who is there to recognise her?

¹ See Chapter Seventeen : Visitation : The Need

² See Chapter Twenty-one : Visitation : The Facts and Circumstances giving Rise Thereto

Obviously there are those who recognise her as an institutionalised resident. But who is there to recognise her as a person? It is those who visit her. It is her family, her friends and the specialised visitor. It is they who accord her status, standing and rank. It is to them that she means something.

But there are limitations.³ So much so that some of the residents receive few or no visits. But the specialised visitor is not subject to these limitations.⁴ His pattern of visitation is characterised by continuity and regularity. This continuity and regularity gives the resident something to which she can look forward. It is not something that occurs on odd occasions; nor is it something that may occur once or twice and not again. The visits of the specialised visitor are continuous and regular.

20.3 FREQUENCY

Not only are visits, in terms of the specialised visitation programme, continuous and regular, but they are frequent. The observation has been made that provision is made for each resident to be visited eight times a month but depending upon the circumstances of the resident, these visits could be more frequent.⁵ When a need presents itself in the life and experience of the resident, or a personal distress occurs, the specialised visitor is available to visit the resident.

20.4 PERSONAL CONTACT

The resident, obviously, has personal contact with a variety of people. But it is 'channelled contact', that is to say, contact in a restricted and definite direction and aimed at a particular end. For instance, the resident's contact with the medical or nursing staff is not open to a wide or general ambit but is directed towards an end

³ See Chapter Eighteen : Visitation : The Normal and Regular Pattern

⁴ See Chapter Nineteen : Visitation : The Specialised Pattern; see also Chapter Four: Specialised Visitor

⁵ See Chapter Nineteen : Occurrences of Visitation: Regularity of Visitation

which, by and large, is closely connected with medical matters, or matters concerning health or matters relating to nursing activities. Likewise, the resident's contact with the domestic staff is, generally speaking, limited to the ambit and scope of domestic matters such as the meals which are served or the cleaning of the rooms. The contact is circumscribed and confined.

This 'channelled contact' does not apply to the resident's contact with the General Manager or the administration. Although, in many instances, the contact with the General Manager or the administration is limited and restricted, the General Manager and the administration are keenly aware of, and interested in, the wider context of the resident's life and experience. Accordingly, they are always open to contact with the resident on a broader front. But time is always of the essence and neither the General Manager nor the administration is able to give to the resident the personal contact that is desirable.⁶

The specialised visitor is not subject to the constraints which limit or confine his personal contact with the resident, nor is time a factor that warrants consideration. He is not subject to any discipline which is his particular interest and in respect of which he wishes to gain information from the resident, nor is he bound by any approach which is likely to dominate his contact with the resident. His personal contact with the resident is not 'channelled', in that, it has no restricted or defined direction, nor is it aimed at a particular end. His personal contact with the resident is open, accessible, unobstructed, and sincere.

20.5 CONCERN

Moreover, his personal contact with the resident is motivated by concern, a concern, which has been observed⁷ to be written into the Constitution of the Home. The Mission Statement declares that the primary concern of the Home "is for ladies who are elderly, infirm and needy; to respect their rights, to accord them dignity, to attend to their welfare, and ensure their freedom from danger, care, or fear."⁸

⁶ See Chapter Five : *The Administration and Personal Contact*

⁷ See Chapter One : *Introduction*

⁸ *The Ladies Christian Home Constitution para. 2*

Why does the specialised visitor visit the residents? Firstly, because they are old, infirm and needy. Secondly, because, despite their age and condition, he respects them as persons with rights. Thirdly, he visits the resident because he wishes to accord her dignity, to honour her, to elevate and exalt her in rank, station and standing. Fourthly, he visits her to attend to her welfare, her happiness, her comfort, her contentment and well-being. Fifthly, he visits the resident, personally, to make sure that in her mind and heart, she is free from danger, care and fear. The key to an appreciation of this aspect of the benefits and advantages of visitation lies in the first reason advanced, namely, 'because she is old, infirm and needy'. The best of life has been lived and what is left is precarious. But because it is precarious does not mean that it need be hazardous, insecure and doubtful. Hence the concern on the part of the specialised visitor.

20.6 INTEREST

What is the main desire of someone who is old, infirm and needy? What rights does such a person seek to exercise? What dignity does a person who is old, infirm and needy still possess? What are the principal aspects of her welfare that requires attention? How does anybody ensure that she is free from danger, care, or fear? The answer to these questions lies in the mouths of those who are old, infirm and needy, and probably, the answers will differ from person to person.

It is suggested that among these answers will be one that indicates that nothing more is desired than that someone should take a genuine, continuing and lasting interest in them as a person. Does the passage of the years transform an individual with her own particular personality into an object or thing which is lacking in personality, individuality, humanity or interest? When one has regard to the interest which is taken in some residents, this is not an easy question to answer. It should have a single, obvious and simple answer, but it has not.

This statement admits for one certain exception: the role played by the specialised visitor. The interest taken by a specialised visitor is not in a person who is old, infirm and needy; but in a person. The rights in which he takes an interest, are the rights of a person; he is interested in the dignity of a person, the welfare of a person; his interest is to ensure freedom from danger, care or fear of a person. His interest lifts his vision from age, infirmity or need to a person, to an individual, to a human-being.

20.7 CARE

The practical effect of personal contact with a resident, as well as concern and interest for the resident, is the demonstration of care. This implies a number of things; it implies the giving of careful attention to a resident; of taking notice of a resident; of having regard for a resident. It implies a watchful caring of a resident, as would be the case of a patient being placed under the care of a doctor, or a ward being placed under the care of a guardian. Constitutionally, it imposes a duty to attend to the welfare of a resident, and to do all things necessary to ensure that the resident is freed from danger, care or fear.⁹

A specialised visitor cannot be detached from a resident. By the very nature of the vocation, he becomes involved in the lives, experiences and interests of the residents. Their physical and mental conditions are his concerns; and their emotional problems become his concerns. A number of warnings need to be raised in this regard.

The specialised visitor must exercise care within the nature and scope of his calling. He does not assume the role of medical doctor or of nursing sister; he does not assume the role of geriatric psychiatrist, or gerontologist or psychologist; he does not become the General Manager, nor does he become part of the administration. He is, and always remains, a specialised visitor and the care he demonstrates must always fall within the ambit of his vocation.

⁹ *The Ladies Christian Home Constitution para. 2 (Annexure A)*

This does not mean that the care demonstrated by the specialised visitor is lacking in effectiveness. It must always be borne in mind that the specialised visitor has direct access to the administration, the General Manager, or the Board of Trustees, in respect of matters which he considers to be beyond his powers or control.

20.8 INTERVENTION

The role of the specialised visitor to intervene in the affairs and experiences of a resident must be treated with care. The mere fact that he fulfills the function of specialised visitor does not authorise him to do what a resident elects to permit him not to do. In other words, he has no automatic right to intervene in the concerns of residents. He does so only when, expressly or by implication, he is enjoined so to do by the resident.

When so enjoined, he fulfills an important role. The situation giving rise to intervention on the part of the specialised visitor, presupposes the resident encountering a state of affairs with which she cannot cope and requires intercession on the part of the specialised visitor. It may be a comparatively simple matter which can be easily dealt with or it may be a matter of a more pressing nature which requires discussion and some form of intervening action. Whatever the situation, the fact of the matter is that the resident is in need of help and she has no one in whom she has sufficient confidence to whom she can turn to resolve the problem. This is the role and function of the specialised visitor. It takes time and effort to build a relationship of confidence and trust but it can and does occur through regular and continuous visitation.

20.9 SUPPORT

The specialised visitor is available to assist a resident in a time of need, or, at least, to offer his support. This statement must not be misconstrued. It does not mean that

in all situations, the resident can call upon the specialised visitor to strengthen the resident's cause or position by relying upon the assistance or approval of the specialised visitor. This could place the specialised visitor in an invidious position, as it presupposes that in every situation of conflict or confrontation, the specialised visitor would have to ally himself with the cause of the resident. He may not be able to do this, nor is it expected of him to do it.

The support that the specialised visitor is able to offer the resident is to comfort or strengthen her, as in time of need.¹⁰ Despite the fact that the resident may be wrong in her conduct, demeanour or attitude, the specialised visitor can still sustain, help and assist her, or offer to her succour, relief and comfort. In so doing he can give her strength, courage and confidence.¹¹

In situations of conflict and confrontation (which frequently occur), the resident often feels alone and vulnerable. Two factors militate against a resident in situations of conflict or confrontation with administrative instances. The first is that in a clash with, for instance, the nursing or domestic staff, the staff can usually muster support for their cause, or, at least, offer a plausible explanation as to reasons for their conduct. The second is the condition of the resident, either from a physical, or mental, point of view. Such does not usually lend itself to self-assertion or decisive action. But whatever the situation, and even if it involves a fellow-resident, the support (and intervention) of the specialised visitor, can diffuse the situation and introduce a calmness and composure.

20.10 STABILITY

Something which is stable is not easily moved or shaken; it is persistent without essential change; it is permanent and enduring. Life for many of the residents is quite the opposite; it is transient. However positive any resident may be, she harbours the thought that life is not lasting; indeed, it may be of brief duration even momentary.

¹⁰ *MacMillan Contemporary Dictionary* (MacMillan Publishing Co. Inc 1979) see : "support"

¹¹ *World Book Dictionary* (Field Enterprises Educational Corporation 1975) see : "support"

Into this situation enters the specialised visitor, continuously and regularly. He makes personal contact on a frequent basis; he manifests care and concern. He shows a genuine interest in her affairs, he intervenes and takes initiative in situations marked with uncertainty; situations which are uncertain, indefinite and unsettled.

Despite her advanced age, her frailty of body, and wavering concentration, she sees in the specialised visitor someone who offers to her unqualified support and introduces a spirit of stability; something of permanence and a lasting quality.

20.11 CERTAINTY

Associated to the quality of stability is that of certainty, which, in turn, is linked to confidence and assurance. The resident is certain that she is elderly, in particular instances, she is certain she is infirm, in some cases, she is certain she is needy. But that is where her certainty ends.

It is the specialised visitor who recognises her personality and her individuality; it is he who recognises that, despite her age, she still possesses rights and it is he who accords her dignity. He makes sure that her welfare is attended to. Life comes to have meaning and purpose; there is still something for which to live. The specialised visitor assures her of her freedom from danger, care and fear.¹²

The resident's life assumes a quality of certainty. What was indefinite becomes more clearly defined, it becomes positive, certain and sure, it assumes an aura of reality. Monday is not just another day, it is a day with a programme in which the resident can participate. Tuesday provides an opportunity to worship. This is not a mere possibility, it is certain; it will occur. Wednesday makes shopping a reality; if not by the resident, then by another resident. Thursday makes the resident consider the benefits of exercising her body and improving the quality of her life. Friday provides the opportunity to exercise body and mind and partake in social activities. These are realities; these are certainties.

¹² *The Ladies Christian Home Constitution para. 2*

20.12 SECURITY

Security, in keeping with the Constitution,¹³ and definition,¹⁴ means freedom from danger, worry, care, or fear. It implies a state of being certain or guaranteed. And indeed, as has been repeatedly stated, it is the primary concern of the Ladies Christian Home. Wherein lies the security of the residents, and how can they be assured of freedom from danger, worry, care and fear?

Where insecurity dominates the physical, and possibly, the mental state of the resident, security manifests itself, in the first place, in the provision of a home within which to live with all the attendant facilities. Secondly, security manifests itself, in the provision of wholesome sustenance, the medical care of body and mind, and the general welfare of the residents. Thirdly, and among other things, security manifests itself, in giving encouragement to the residents to live life to the full, and enjoy exhaustively the years that lie ahead.¹⁵

The specialised visitor is motivated and constitutionally authorised to ensure that residents are secure and that they feel secure.

20.13 AUTHORITY AND INFLUENCE

The specialised visitor enjoys a considerable degree of independence. He is not employed by the Ladies Christian Home. The General Manager does not purport to exercise authority over him. The administration does not interfere with the visitation programme, indeed they support it. He is answerable only to the Board of Trustees. At the same time, he does not meddle with the General Manager in the exercise of her managerial duties; he does not interfere with the affairs of the administration; and he does not fly in the face of the Board of Trustees. He is respected by the residents in his capacity as Chairman of the Board of Trustees and his duties as specialised visitor are valued and appreciated by the residents.

¹³ *The Ladies Christian Home Constitution para. 2*

¹⁴ *MacMillan Contemporary Dictionary (MacMillan Publishing Co. Inc. 1979) see "Security"*

¹⁵ *The Ladies Christian Home Constitution para. 3*

In his various capacities he possesses authority, control and influence. The extent to which he is likely to exercise such authority, control or influence is debatable but it is there and the residents know it. He is often requested by certain residents to use his authority and influence, and sometimes he is able to do this without causing offence or displeasure. At times the requests do not warrant intervention. What is required is to assess the request and if it warrants some sort of action, simply to discuss it with the General Manager or the Administration to see if something needs to be done, and if so, how best to do it.

The benefit or advantage that is being advanced is that there is, for the resident, an independent authority to whom she can turn and who will objectively and impassionately consider her plea.

20.14 CONCLUSION

The benefits and advantages of specialised visitation have been viewed in isolation. An argument has been advanced that such benefits and advantages do exist and that they justify the introduction of a programme of specialised visitation. The facts and circumstances giving rise to such a programme of visitation need to be considered and it is to this matter that attention is now directed.

Chapter 21. THE FACTS AND CIRCUMSTANCES GIVING RISE TO VISITATION

21.1 INTRODUCTION

Consideration is now given to the facts and circumstances which give rise to a programme of specialised visitation. Stated otherwise, what situations present themselves in the experience of the resident that advance the argument that specialised visitation enhances and improves the quality of life of the resident? The need for visitation has been analysed and assessed.¹ The conclusion was reached that the process of institutionalisation gave rise to intrenchment and isolation, which in turn, gave rise to the need for visitation.² The wider picture is now investigated to determine whether the facts and circumstances in which the resident finds herself are such as to justify the introduction of a programme of specialised visitation.

21.2 HOME FOR THE CARE OF THE ELDERLY

The first observation that stands to be made is that the resident is in a Home. She has been institutionalised. This means three things in particular. It means that home, as it was, is no longer home; it is something of the past, it is a memory. Secondly, it means that home is now Home; a building of considerable proportions, a family of enormous size. Thirdly, it means a huge adjustment on the part of the resident. Some readily and easily adjust. Some never adjust. But whether there is adjustment or not, the fact of the matter is that institutionalisation means an immense change for the resident. The question that arises is whether she must be left to face it alone, or whether she must be supported. The answer is obvious. Of course, she must be supported. And she is supported by visitation, in accordance with the regular or normal pattern, or in accordance with the specialised pattern.

¹ See Chapter Seventeen : Visitation : The Need

² See Chapter Seventeen : Conclusion

21.3 ADVANCED AGE

A fact that the resident must accept is that she is aged, she is elderly, she is old. She may be a few years younger than the average age of eighty-six; she may be a few years older. But whichever way you look at it, she is of advanced age. What are the thoughts she harbours? She alone knows. Certainly, she must think that the move she has made into the Home, is the last move she will make before she dies. What are her thoughts about death? Her husband is dead. Many of her contemporaries are dead. Perhaps, some of her own children are dead. Has she been admitted to the Home to die? What thoughts, if any, does she have for the future, and does she make any plans? Does life consist of daily segments of twenty-four hours each? How is this situation made more constructive and how is life made more a process of living than merely a process of existing?

The young, or, at least, the younger, are not called upon to harbour these thoughts or devise possible answers. But can they not make the life of the resident such that these thoughts are either not entertained, or at least, are deferred? If they cannot radically alter the pattern of thought, they may, at least, diffuse it.

Two things are certain. One is that the resident is old and she must live with her thoughts concerning her age. The second is that the visitor, according to the normal or regular pattern, or according to the specialised pattern, can alleviate this pattern of thought, by introducing new ideas, new notions, new imaginations, new images.

21.4 INFIRMITY

To a lesser or greater degree, the resident must, invariably, live with some form of infirmity, even if it be the mere infirmity of advanced age. This may be an aspect of physical infirmity, or of mental infirmity. In many instances, physical infirmity is,

for the visitor, easier to live with than mental infirmity. The use of a walking-stick, a walker or a wheelchair is acceptable and tolerable, but the onset and intensification of forgetfulness, irrationality and some form of senile dementia is very upsetting, in that, the visitor realises that the gradual loss of the resident has irreversibly commenced.

But whatever her situation, the resident must, consciously or unconsciously, live with the fact of the gradual (or rapid) decline. This infirmity is sometimes a cause exasperation, even aggravation, on the part of the family, to the extent that they choose not to visit the resident, or, to visit her only irregularly.

But this ought not to be the case. The primary concern of the Home “is for ladies who are . . . infirm . . .”³ It ought also to be the primary concern of the visitor. Infirmity should give rise to visitation, not detract from it. The resident ought not to bear the burden of her infirmity alone.

21.5 NEEDINESS

The founders of the Ladies Christian Home sought to provide a Home for indigent ladies and a primary concern was for ladies who are needy.⁴ The majority of the residents fall within this category. Indeed, in respect of certain needy residents, the Home regards them as charity instances, and fully subsidises them.

The needy are as deserving of visitation as the rich. But very often it is not forthcoming. What needs to be said must be said with sensitivity and care. The needy have little to give in life and in death. Materially, they hold out little incentive for visitation. There is nothing to be gained in life or on death. The impression is gained, and it is no more than an impression, that the residents who

³ *The Ladies Christian Home Constitution para. 2*

⁴ *The Ladies Christian Home Constitution paras. 1, 2 and 3*

are more adequately endowed, receive more visits than those who are needy. This admits of an exception. It is a fact that certain visitors do visit needy residents to get whatever is on offer by the generous indigent, who will deny herself in order to benefit a family member.

The specialised visitor does not distinguish between the needy and the rich. He stands to receive no benefit; he seeks no benefit other than an enhanced quality of life of the resident, whether needy or wealthy.

21.6 ILL-HEALTH

Apart from physical and mental infirmity, the resident, probably by reason of advanced age, is susceptible to ill-health. This, obviously, is primarily the concern of the medical and nursing staff but it is also the concern of the visitor. The visitor, according to the normal or regular pattern, often misses these periods of ill-health because of the irregularity of visitation. The resident, on the other hand, looks for solace and succour during these periods. And she finds it in the continuity and regularity of the visitation of the specialised visitor. The frequency of his visits assists him, not only in instituting inquiries regarding the ill-health of the resident, but by making his own observations.

What is being referred to is not serious ill-health. Serious ill-health invariably causes concern and the family responds by acts of visitation. The ill-health alluded to is minor ill-health which is felt most keenly by the resident. It is she who is needful of caring concern and interest; it is she who appreciates personal contact and frequency of visitation, such as can be given by the specialised visitor.

21.7 ADVERSITY

This is a condition which is marked by unhappiness, misfortune or distress. It is not a condition which easily escapes the resident. Nor is the cause thereof readily

detectable. It is seldom treated by medical or nursing care and its cure is not found in a pill or dose of medicine. The resident is slow to admit to the condition but the signs are there to observe. It may be in a fixed stare, or an expressionless face, or a flood of tears.

It could be rationalised on the basis of advanced age coupled with a feeling of worthlessness, or hopelessness, or the anticipation of death. Tiredness, a lack of purpose, a deficiency of any forward planning or imaginative exercise, may all contribute to the condition. But whatever the cause, the resident must be lifted from the condition as it can lead to despair and even a longing for death.

It is the family, or visitors, or specialised visitor who must do the healing work. It is they who must attend to the welfare of the resident; to give them a sense of worth, to give them hope and a purpose for living. They must devise means to dispel the unhappiness, misfortune or distress. In so doing they will enhance the quality of life of life of the resident.

21.8 APATHY

Apathy means a number of things, all of which are injurious to the quality of life of the resident, and all of which must be avoided if at all possible. Apathy means a lack of interest or desire for activity. It implies unconcern and impassivity on the part of the resident. It incorporates an attitude of indifference, that is to say, not caring one way or the other, or not caring enough to take a real interest. There may well be an exception to this general meaning in the sense that apathy may suggest indifference to everything except one's own troubles, sorrow or pain. In other words, the resident becomes obsessed with a single factor only, such as her own health, or her own pains, or that someone is stealing all her goods or money.

It is easy for a resident to become apathetic if she is left to her own devices. She needs to be stimulated, excited and encouraged. Indeed, the first signs of apathy give rise to the need for frequent, continuous and regular visitation. It demands that the visitor, by way of personal contact, takes a caring concern and interest in the affairs and attitudes of the resident.

21.9 LACK OF VISION

Closely akin to apathy is a lack of vision in the sense of something being seen in the imagination or in one's thoughts, or even in one's dreams. All too often the old person loses her ability to imagine anything, to give any thought for the future, or to dream a dream. Life is lived in the past, or perhaps, in the present in the sense that when the bell rings, it is time for breakfast or lunch. The future, if it exists, exists only in the sense that on Tuesday (whenever that may be), church is held, or on Friday, it is Bingo. The vision for the future is confined to a regular or definite pattern; there is no creativity about it. There is no need to exercise the imagination; all that needs to be imagined, has already been imagined. And there is no need to think, as all the thinking is done for you.

It is true that the Home organises activities that provide for mental stimulation but, by and large, these activities are poorly supported. Bingo is a popular activity but one would hardly describe it as an activity which widens the scope of the resident's vision.

The scope of the resident's vision is widened by imaginative and planned acts of visitation. The extent of the resident's vision must bear no relation to the number of years she has lived, or the number of years she is expected to live. The visitor must always be alive to stimulating the imagination of the resident, and giving her cause to think and to reason.

21.10 LACK OF SELF-ESTEEM

To hold someone in esteem is to have a very favourable opinion of that person, or to regard that person highly. Self-esteem is to think well of oneself, or to have a measure of self-respect. The passage of time is the robber of self-esteem. What was once a beautiful face, is now lined and drawn. What was once a graceful body, is now shapeless and lacking in attraction. What was once a comely head of curled and combed hair, is now thin, straggling and white. What once sported the height of fashion, is now old and dowdy. The question that the resident must ask herself is: who cares? Who does care?

To a certain extent, the staff cares but this goes only as far as the clothes being clean and the resident being properly dressed. Who is there to say : your hair looks so pretty today, have you had it done? Who is there to say : you really do look so nice in that dress. These are simple statements but not very often heard. Not often heard, because there is no one to say them. And when they are said, they make such a difference because they are so appreciated. They give the resident a reason to think well of herself; it restores her self-respect; it accords her dignity.

It takes acts of visitation to achieve this end. And where they are lacking, the effects are devastating. The natural result of a lack of self-esteem is slovenliness, carelessness and untidiness.

21.11 FEAR

One of the primary concerns of the Ladies Christian Home is “to ensure their freedom from . . . fear”.⁵ What does a resident have to fear? She fears the frailty of her body; of stumbling and falling as she walks. She fears breaking a hip, or some other bone of her legs and arms. She fears falling out of bed during the night, and not reaching the night-bell. She fears hospitalisation, with all its formalities,

⁵ *The Ladies Christian Home Constitution para. 2*

technicalities, and postponements. She fears that she is becoming more forgetful, and she fears, especially, that this may lead to some form of 'madness' (dementia). She fears that her mobility is decreasing and that soon she will be confined to a wheelchair. She fears the pain that racks her body; especially as no form of medication seems to relieve it. Fear is one of the facts and circumstances that give rise for the need of visitation.

Medical and nursing attention can go so far but, often, it is not far enough. It is for the visitors to hearten, cheer and comfort the resident. The resident cannot be left alone with her fears and it is only in acts of visitation that sufficient assurance can be given to lift the burdensome load of fear.

21.12 ENCOURAGEMENT

One of the objects of the Constitution is "to provide a means whereby . . . encouragement may be given to the residents of the Home . . ." ⁶ Encouragement means a number of things, not the least of which is to increase the hope or confidence of the resident. It also means to urge on, to help, to support, to hearten and to inspirit. ⁷

Who is to do all this? It is suggested that this is the strongest argument in support of the introduction of a programme of specialised visitation. More than all things else, the resident needs hope and confidence. When body is frail and mind is becoming increasingly feeble, what is there left but to "urge on, to help, to support, and to hearten and inspirit". This is to enhance and improve the quality of life of the resident.

⁶ *The Ladies Christian Home Constitution para. 3.3*

⁷ *The World Book Dictionary (Field Enterprises Educational Corp. 1975) See : "encourage"*

21.13 CONCLUSION

The facts and circumstances giving rise to a programme of visitation have been enumerated and investigated. It is contended that they advance the argument in support of the introduction of a programme of specialised visitation. The subject of visitation is drawing to a close but is not yet completed. One subject that requires consideration is the religious and secular aspects of visitation. These matters will now be investigated.

Chapter 22. THE RELIGIOUS AND SECULAR ASPECTS OF VISITATION

22.1 INTRODUCTION

There are two aspects of visitation that stand to be considered. One is the religious aspect of specialised visitation, and the other is the secular aspect thereof. The question that arises is why must these two aspects, in particular, be considered. One answer is that they are indicative of the essential nature and character of visitation.¹ Another answer is that they are indicative of the requirements, characteristics and qualifications of the specialised visitor.² These are not matters which are singled-out as giving rise to interesting academic discussion. They arise out of numerous acts of visitation which have taken place over a period of two years.

If one accepts that by 'religious' one necessarily implies a connection with religion, or even, perhaps, being devoted to the worship of God, one ought not to be surprised that religion plays an important role in the matter of visitation. The observation has been made that, originally, the name given to the Home was 'The Christian Home for Aged, Infirm and Indigent Ladies, and for Christian Workers', later this was altered to 'The Ladies Christian Home'.³ The Christian religion clearly plays an important role in the *ethos*, character and disposition of the Home. But apart from the name the spiritual significance of the Home must emerge from its Constitution insofar as it applies to the matter of visitation.

22.2 THE RELIGIOUS ASPECTS OF VISITATION

The Preamble to the Constitution states:-

¹ See Chapter Eighteen : The Normal and Regular Pattern, and Chapter Nineteen : The Specialised Pattern

² See Chapter Twenty-Four : The Visitor : Requirements, Characteristics and Qualifications

³ See Chapter One : Background

“The purpose of the founders was to provide a Home for aged and indigent Ladies; such to be run on stated religious principles namely Evangelical, Protestant and non-sectarian.”⁴

The Mission Statement set forth in the Constitution states :-

“It (the Home) recognises the importance of material things and of humanistic concerns but its primary motivation is neither materialistic or humanistic. In all its endeavours it is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares.”⁵

The Objects of the Home shall be:-

- “3.1
- 3.2
- 3.3 to provide means whereby spiritual guidance, teaching and encouragement may be given to the residents of the Home; all such to be consistent with and supportive of the Mission Statement and in keeping with Evangelical, Protestant and non-sectarian principles;
- 3.4 to provide as far as is reasonably possible for the presentation of the gospel of salvation through faith in the Lord Jesus Christ.”⁶

⁴ *The Ladies Christian Home Constitution : para. 1*

⁵ *The Ladies Christian Home Constitution : para. 2*

⁶ *The Ladies Christian Home Constitution : paras. 3.3 and 3.4*

In providing for the appointment of a Board of Trustees the Constitution makes provision for:-

“... one Trustee appointed by each of the following Denominations : the Baptist, the Dutch Reformed, the Church of England in South Africa, the Methodist and the Presbyterian.”⁷

The Constitution makes provision for the appointment of a General Manager who shall be:-

“... one who is in sympathy with and supportive of the general principles upon which the Home is structured.”⁸

The intention and implications of the Constitution are clear and unambiguous. Manifestly, it has a strongly religious inclination and is supportive of action, conduct and conviction which is evangelically Christian, Protestant and non-sectarian. But the religious bias does not stop there. It evinces itself in much of the activity in which it engages and the actions which it supports.

For a number of years, and up to about two years ago, it engaged the services of a part-time clergyman of the Christian faith to visit and spiritually minister to the needs of the residents. This involved both the reading of the scriptures and engaging in prayer with them. There is little doubt that they, expressly or by implication, sought to lead the residents, in appropriate circumstances, to a personal commitment of themselves to the Lord Jesus Christ.⁹

Moreover, to this day, a weekly half-hour Bible study is conducted by a clergyman of the Christian faith. After the conclusion of the study, the clergyman and his wife,

⁷ *The Ladies Christian Home Constitution : paras. 4.1.2.2 and 5.1*

⁸ *The Ladies Christian Home Constitution : para. 5.4*

⁹ *The Ladies Christian Home Constitution para. 3.4*

for a period of about two hours engage in a programme of visitation (primarily but not exclusively) to those in the Frail Care Wing of the Home. The intention of this ministry is to serve the spiritual needs of the residents, to read to them from the scriptures, and to pray with them, if this is desired.

Furthermore, once a week, and for a period of about one half-an-hour, a service of Divine Worship is conducted by one of the denominations represented on the Board of Trustees i.e. Baptist, Dutch Reformed, Church of England in South Africa, Methodist and Presbyterian.¹⁰ Once a month the Sacrament of Holy Communion is administered. Occasionally, the participating minister spends time after the service socialising with the residents over tea, or visiting members of the particular denomination in their rooms. Residents, unless excused, are expected to attend this service of worship. It may be noted that in the unusual situation of the appointed clergyman not presenting himself for his appointment, the specialised visitor fulfils the role.

Grace is said at all meals, and at certain meals, a time of devotions is led by one or other of an appointed group of residents. The duration and intensity of the acts of devotion depend, to a large degree, on the personality and conviction of the presenter. Generally speaking, the nature of the acts of devotion are evangelical and fundamental.

Some of the residents engage in religious activity on a personal and private basis. While engaged in visitation, the researcher has encountered a number of residents participating in Bible reading and prayer. Moreover, from time to time, he is requested by the resident to pray with her or to offer scriptural encouragement and spiritual advice. This need not be limited to situations of private, personal devotions but also where the resident is ill, or depressed, or discouraged.

¹⁰ *The Ladies Christian Home Constitution : paras. 4.1.2.2 and 5.1*

It emerges from the name of the Home, the Constitutional assertions, and spiritual activity that religion plays an important role in the function and operation of the Ladies Christian Home. This gives rise to a number of questions. The first is: must not any programme of visitation fit squarely into the religious emphasis of the Home? The second is : must not any programme of visitation be essentially religious in character. The third is : if the programme of visitation is not essentially religious in character, to what extent is it religious and to what extent is it secular? These questions are of considerable importance as they have direct bearing on the nature and character of a specialised programme of visitation. They will be addressed presently.

22.3 THE SECULAR ASPECTS OF VISITATION

It is important, in considering the nature of any programme of visitation, that not all residents claim to be practising Christians. It is not a requirement of admission to the Home to subscribe to a declaration of faith, that is to say, a submission to the Christian faith. Indeed, not all residents claim to be religious, that is to say, to believe in God, or to Worship God. While it is asked of applicants what is their denominational affiliation, if any, it is not a requirement of admission, to have a denominational affiliation.

Moreover, the problems with which a specialised visitor will have to deal are not all spiritual problems. Indeed, the nature of acts of visitation, are by and large, more often secular than religious. An act of visitation is usually some meaningful contact or engagement and may be no more than a greeting, an inquiry directed at the state of health of the resident, and some farewell words of encouragement or upliftment. It is seldom ponderous or grave, and even where it is, it may not be expedient to embark upon a religious approach.

It is to be borne in mind that specialised visitation is directed at a long-term project, and not on the basis of 'here today, gone tomorrow'. It is all to do with the building up of confidence, of dependence, and trust.

Accordingly, where the specialised visitor adopts an over-eager or purely religious approach, he is often met with inhospitality and coolness. A cogent argument can be advanced that a secular approach to residents is to be preferred to the purely religious approach. Whereas a purely religious approach is acceptable to evangelical Christian residents, it is not acceptable to non-evangelical Christians, non-Christians and irreligious residents. On the other hand, a secular approach is acceptable to all residents, provided, of course, it can be adapted to incorporate a religious nature, where the occasion demands.

A purely secular approach also has disadvantages. Whereas it is adequate to initiate discussion and to deal with secular problems, it is not adequate where the resident raises problems which require the religious approach. It would seem that a single approach, be it purely religious or purely secular, can have its limitation. Wherein lies the answer to the problem?

22.4 COMBINATION OF RELIGIOUS AND SECULAR APPROACHES

The specialised visitor has to bring himself within the scope of Constitution. There may well be flexibility in his approach if the name of the institution was the only factor to which he had to have regard. Likewise, if he had to have regard only to the activities of the Home. But he is bound by the Constitution and this leaves him no scope for flexibility. In due course, the requirements, characteristics and qualifications of the specialised visitor will be considered.¹¹ At this stage, no more need be said than that the specialised visitor will encounter problems that give rise to a religious approach; he will encounter situations that residents seek prayerful

¹¹ See Chapter Twenty-Four : *The Visitor : Requirements, Characteristics and Qualities*

intervention; he will encounter cases in which a Biblical knowledge will be required; and he may encounter instances where he is required to lead an act of divine worship. He is not required to be a student of theology, nor is he required to be a Biblical scholar.

He is required to be no more than a specialised visitor. But this may well entail a sufficiently wide religious experience, knowledge of God, and fluency with the Bible to cope with an elderly person who raises a spiritual problem, or who seeks to be comforted and reassured spiritually. This is not likely to crop up frequently or regularly. But it is certain to present itself and the specialised visitor must be ready and able to deal with the situation.

But the Constitution does not exclude secularity. The mere fact that as a Home it operates in the world, implies an element of worldliness. And certainly from the point of view of visitation, a secular approach must be part of its essential nature. However much the Constitution may incorporate aspects of religion and by implication, incorporate religion, and especially the Christian faith, into any visitation programme, it cannot place its stamp of Constitutional approval on godly talk only. People must be discussed; conditions must be discussed; situations must be discussed; national and international events must be discussed. Just because residents are old does not mean that they are disinterested in events occurring round and about them. Some of them entertain an expertise in sport. This is life, and it is life that must be lived. And we live it by talking about it. Thus it forms an integral part of a programme of visitation.

This forms the substance of regular and continuous contact. This gives rise to contact, to conversation, to friendship, to confidence.

Secularity in a programme of visitation, sooner or later, gives rise to all the aspects of religion which are raised in the Constitution, and forms the basis of specialised visitation in keeping with the Constitutional intention and implications.

The secular approach does not stand alone; nor does the religious approach. Together, within the context of a programme of specialised visitation, it achieves the desired end.

22.5 CONCLUSION

There are both religious and secular aspects of specialised visitation. Observations have been made in this regard. One further aspect of visitation needs to be investigated, that is, the reaction thereto and the receptivity thereof by the resident. This forms the subject matter of the next chapter.

Chapter 23. REACTION TO AND RECEPTIVITY OF VISITATION

23.1 INTRODUCTION

From the beginning of March 1998 until the end of February 2000 a continuous programme of specialised visitation was conducted at the Ladies Christian Home. During this period approximately ten thousand acts of visitation were carried out. The programme continues. The nature of the acts of visitation differ considerably one from the other. The vast majority constituted no more than a call or short visit to the resident. But each is significant in at least two respects. The first is that, however short the visit, rational and effective contact was made. This contact, on its most basic level, expressed itself in a greeting, followed by an inquiry into the situation that pertained to the resident (usually related to the condition of her health) and concluded by some parting word of greeting or a word of encouragement or comfort. This statement stands to be qualified. Certain of the residents (especially those in the Frail Care Wing) are *non compos mentis* or in an advanced state of senile dementia. Oral communication is not possible. A visit will comprise sitting with such a person and either holding her hand, or smoothing her hand or face, or some other form of tactility. The fact of the matter is that meaningful contact is made, even though no conversation is exchanged.

The second significant respect lies in the regularity of the acts of visitation. This, as has been repeatedly pointed out, is the distinguishing feature between the normal or regular pattern of visitation and the specialised pattern of visitation. Continuity and regularity are key features of the programme and form the basis upon which observations are made in regard to the reaction of residents to specialised visitation and their receptivity thereof.

While calls or short visits to residents form the greater part of the programme, it is not suggested that all visits are of this nature. Indeed, as will be observed, with the passage of time and the development of meaningful relationships between residents and the specialised visitor, significant and purposeful acts of visitation occur.

Acts of visitation cannot be viewed in isolation, nor can any deductions be made from such visits. In order to determine the reaction of residents to the programme of specialised visitation and their reception of the programme, it must be viewed over a passage of time. Indeed, it is suggested that the longer the period of visitation and the greater the number of acts of visitation, the more valid are the observations made and the deductions drawn. Obviously, this will involve a certain amount of generalisation, to which there will be exceptions. But the fact remains that the programme has operated for over two years, and a considerable number of visits have taken place. Accordingly, it is submitted that it is valid and justified to make observations and deductions relating to the reaction of residents to the programme of specialised visitation and their receptivity thereof.

23.2 REACTION AND RECEPTIVITY

The start of the programme was characterised by an unmistakeable attitude of suspicion on the part of the residents. This was not surprising, especially on the part of those who had been resident at the Home for some years. Such visitation as had taken place, accorded with the normal or regular pattern, or, at best, accorded with the visitation programme of the General Manager. In contrast to this accepted and acceptable practice, a male stranger presented himself at the resident's door, introduced himself as the Chairman of the Board of Trustees, and proceeded to initiate an inquiry into the residents health and condition. In retrospect, there is little doubt that the launch of the programme could have been done in a better way but everything was new and it was very much a case of trial and error. Let it be said that

the introduction by the specialised visitor of himself as Chairman of the Board of Trustees did help a little, but there is little doubt that for the most part, the residents (or at least the majority of them) harboured suspicions in regard to the specialised visitor.

Associated to the attitude of suspicion, was an attitude of reserve. A situation of strangeness and suspicion, must invariably lead to a keeping of one's thoughts, feelings and affairs to oneself, of holding back, of self-restraint, and even of lack of friendliness. Once again, this was not surprising. The mere fact of introducing something new to a group of elderly ladies, especially where this may be viewed as an invasion of the resident's privacy or a minding of her business, is likely to give rise to an attitude of reserve.

But (at the expense of repetition) the contact on the part of the specialised visitor is not isolated or sporadic. It is contact which is continuous and regular. Moreover, it is a contact which shows a genuine concern for the condition of the resident and a real interest in the affairs of the resident. These three factors, taken individually and cumulatively, lend themselves to a breaking down of the attitudes of suspicion and reserve. The openness, genuineness and sincerity which the specialised visitor is able to manifest to the resident goes a long way to the breaking down of barriers between the resident and the specialised visitor and the building-up of goodwill and candidness between them. One of two reactions presented themselves.

One reaction is that of rejection. Rejection of the specialised visitor and rejection of his attempts to make contact with the resident. It is a reaction which is not often encountered. Indeed, when it is encountered, it is not in the form of an outright and complete dismissal. This would obviously smack of impoliteness and discourtesy. Rather, it manifests itself in the form of coldness and disinterest, not uncivil but lacking in enthusiasm and ardour. The specialised visitor leaves the resident in

uncertain mind but under the impression that, to a lesser or greater degree, he was unwelcome. This reaction is not, in all cases, a permanent state of mind. As will presently become apparent, it does, with the passage of time, tend to diminish or dissipate altogether but it does manifest itself as a distinct reaction reflecting upon the receptivity of the programme of specialised visitation by the resident. Moreover, in a very small number cases there are residents who are not entirely enthusiastic about the activities of the specialised visitor.

The second reaction is that of relaxation, that is to say, a loosening or slackening of a rigid and inflexible attitude towards the specialised visitor. This marks a new attitude, an altered state of mind, a change of heart. It marks the commencement of what may become a deep and meaningful relationship between the resident and the specialised visitor; a relationship which, with the passage of time, is likely to quicken and intensify. As a concomitant with the process of relaxation is that of reception. By adopting a new attitude towards the specialised visitor, the resident is, in fact, exposing herself, opening her life and experience to extraneous sources, and, actually or by implication, receiving into the the pattern of her thoughts and emotions one who is willing and able to enhance and improve her quality of life.

The resident, in overcoming her suspicion and reserve, and having adopted a more relaxed attitude towards the specialised visitor, now, more naturally and as a matter of course, engages in coversation with him. Whereas before discourse was largely confined to greetings, formalities, inquiries regarding health, and so on, conversation, on a deeper and more meaningful basis, became something normal and ordinary. The specialised visitor manifested himself as someone who harboured a genuine interest and concern for the resident. Moreover, just as he was prepared to engage in conversation regarding the resident, so he was prepared to speak about himself, his family and his activities. Life began to take on a new significance, horizons widened and there was something to which to look forward in the

continuous and regular visits of the specialised visitor. In the continuity and regularity of visits, something new was introduced into the life of the resident; something deeper than the occasional family visits, something less rushed than the visits to the administration or by the General Manager.

Conversation led to communication or the exchange of ideas or thoughts. Instead of just exchanging comments related to aches and pains, the state of the resident's health, the variety and quality of the food, and the attitude of the nursing or domestic staff, one could embark upon discussions concerning family problems, personal difficulties, and emotional concerns. Communication was most meaningful where the resident was sound of mind. But not all were sound of mind. Some found it difficult to express themselves, others were forgetful and frequently repeated themselves, some were in a state of advanced dementia. Nonetheless, it was possible, in most instances, to communicate, albeit that the communication was confined to some form of tactility. Moreover, an intelligent appreciation of a resident's physical condition can contribute to communication which reaches a level much higher than the puerile question as to how the resident is today. Moreover, the remembrance of the condition, linked to an appropriate inquiry, lends itself to communication on a more understanding and appreciative level. The resident senses a genuine interest and concern in her condition.

This leads to a slow but sure building up of confidence by the resident in the specialised visitor. It must always be borne in mind that the visits are regular and continuous. Where there is a particular condition, the visits may be on a daily basis. In other instances, the intervals between visits are never lengthy. This all leads a firm belief and trust in the specialised visitor. Moreover, the whole situation lends itself to a feeling of assurance that the specialised visitor will not tell others what has been told to him by a resident. This lends itself to confidence in the specialised visitor.

Confidence leads to two further reactions on the part of the resident to visitation. One is interaction and the other is friendship. While these reactions are mostly confined to those who are sound of mind, they are nonetheless very real and very rewarding reactions. Interaction sometimes takes the form of booklending, or participation in the weekly crossword puzzle, or the working on a jigsaw puzzle, or participating in the bi-weekly Bingo competition. These, and other activities, give rise to action and interaction; subject matter on which to talk; and opportunities for banter and laughter. Moreover, the regular and repeated activities build-up friendships so that the parties are no longer strangers, or locked-into a formal relationship of resident and specialised visitor but are genuine friends. The parties take upon themselves the mantle of friendship and emerge as persons who know and like each other.

This, in turn, leads to two yet further reactions both of which are pleasing and rewarding to the specialised visitor. One is a request to come and visit and the other is an expression of vexation where the specialised visitor has been remiss and failed in a pattern of visits to the liking of a resident. Sometimes the request to visit a resident is for a particular purpose. Where this purpose falls within the scope of the activities of the specialised visitor, he will obviously give his assistance to the resident. Where it does not, it gives rise to a problem. It requires tact and diplomacy as the specialised visitor is not wont to meddle in the affairs of the administration or of the General Manager. A careful weighing of tact and diplomacy, on the one hand, and a measure of wisdom and firmness, on the other, usually gives a well-balanced answer to the benefit of all concerned.

It rarely happens that a resident specifically requests the specialised visitor to come and visit her for the purpose of discussing a personal problem. The requests are usually related to some particular end, such as a banking problem, or a letter received from authority or an attorney, so some other event that has given rise to

urgency, or the need for immediate advice and assistance or a situation which the resident cannot handle. Whatever the reason for the request, it indicates some form of need on the part of the resident and it indicates a comfort and a confidence in the presence and the assistance of the specialised visitor.

Personal problems, it may be mentioned, usually arise out of conversation and communication. Although they may be matters causing deep pain and distress, they are seldom raised as 'up front' matters. Rather, the specialised visitor arrives at the point of personal need through discussion, exchange of thoughts and ideas, and an exposure by the resident of her anxiety and point of need.

One of the more pleasing and rewarding reactions of the resident to the programme of visitation and one that reflects an ardent manifestation of the success thereof, is an eagerness on the part of the resident to receive the visitor, coupled with an expression of mild annoyance when the visitor has not been as regular with his visits as the resident expects him to be. It is stated without equivocation and based on many months of experience that the resident eagerly looks forward to the visits of the specialised visitor, thoroughly enjoys these visits, and is disappointed when the regularity thereof is not to the resident's satisfaction.

But not all visits are positive and pleasing. There is a distinct reaction by certain residents to the effect that a visit is an opportunity to voice their complaints. It may be a complaint concerning the management of the Home, or the nature of the nursing services, or the quality of the meals, or the conduct and habits of other residents. Some of these complaints are trifling and petty, and can be easily dismissed. Others are more difficult in the sense that they may bear some substance. The visitor is cast into a dilemma. On the one hand, he is committed to a policy of non-interference in the management of the Home. On the other hand, he is faced with a resident who may have a genuine cause for complaint. Hitherto, two courses

have presented themselves to the specialised visitor. One is that the core of complainers is small and, by and large, they are always the same people. Their happiness seems to lie in complaining, and, if they are not complaining about one thing, then they are complaining about another. Moreover, experience has taught the specialised visitor that there is some form of pleasure to be found in the act of complaining, rather than in seeing the complaint being resolved. This group of residents is easily dealt with. The second course of action open to the visitor is to raise the complaint with the General Manager or the administration in a tactful, sensitive and oblique manner. The General Manager and the administration possess an experience and a skill extending over many years. They recognize a genuine complaint when they hear it, and they are ready and quick to respond thereto. A resident with a genuine complaint will not be neglected and overlooked, nor will she be victimized, simply because she raises a complaint.

Another reaction to visitation on the part of the resident which is unsavoury and displeasing is that of the manifestation of an ulterior motive in the course of a visit. The resident very well knows that the specialised visitor has contact with the Board of Trustees, the General Manager and administration, exercises influence with them, and can 'pull strings'. Accordingly, the resident will welcome the visit of the specialised visitor, not for the usual and accepted reasons of visitation, but for some ulterior motive. She may desire some action on the part of the Board, the General Manager or the administration, or may seek to convey to one or other of them some message, and to this end she will employ some disguised or indirect means. However skillful may be the disguise, or whatever form the message may take, the specialised visitor must be alive to what is his function and role, and the extent to which that function and role is being manipulated and abused.

One final reaction is referred to. In the Home there are a good number of residents who are deeply religious, and find great comfort in the reading of the scriptures and in prayer. They look forward to acts of visitation especially if it brings with them some spiritual comfort and solace. It does not require any great effort, to determine

who these residents are, and what they expect. They can, obviously, be overlooked and avoided but this is contrary to the whole idea of specialised visitation. Experience, albeit limited, has taught the specialised visitor to be versed in *ex tempore* prayer, or, at least, be armed with a book of prayers to which he can have resort. Moreover, to be able to impart a word of comfort and strength by reciting or reading a short portion of scripture is not without its benefits and advantages. It is accepted that this reaction on the part of the resident may lead to requirements that are outside the scope and abilities of the specialised visitor. If this is the case, specialised visitor ought not to avoid the issue but rather enlist the assistance of the appointed Bible teacher or one of the denominational clergyman.

23.3 CONCLUSION

It has been observed that there are clear and definite reactions on the part of residents to the programme of specialised visitation but, in the main, it is enthusiastically and well-received. Indeed, so enthusiastic has been the reaction to the programme of visitation, and so well has it been received, that it has led to this research dissertation, the conclusions arrived at therein, and the recommendations made. It is hoped that the recommendations will lead to further research and favourable reaction.

This concludes the investigation into the many-sided subject of visitation. Attention is now directed to the subject of the visitor. This is the subject-matter of Section G. In Chapter 24, the visitor, in the first place, is seen as individual in the context of certain visitation role expectations. But he is not seen as an individual in isolation. In Chapter 24 he is viewed as fulfilling a specialised role, that is, occupying a position in the social structure of the institution in consequence whereof he is required to engage in a pattern of defined relationships. A number of these relationships are set out in chapters 27, 28 and 29.

SECTION G. THE VISITOR

Chapter 24. REQUIREMENTS, CHARACTERISTICS AND QUALITIES OF THE VISITOR

24.1 INTRODUCTION

It is proposed to deal with a matter of singular significance, namely, the visitor. At the outset of a consideration of the visitor, it may be helpful to reflect upon the sociological concept of 'role'. This embraces, firstly, a position within the social structure of the Ladies Christian Home. Secondly, it embraces a pattern of defined relationships arising out of the position aforementioned. Thus, a person filling the position of specialised visitor is playing a particular role, which, on analysis, can give rise to certain role expectations, and certain role conceptions. These, taken individually, or together, can give to norms regulating role behaviours.¹

It is proposed to look at the visitor from the point of view of ascertaining the expectations, conceptions and norms that need to be present, to launch a programme of specialised visitation. One approach would be to look at a person, assess his qualities, and determine whether he is suited to the situation. Another approach would be to look at the situation, and assess what the situation requires. Once this is done, and the various requirements, characteristics and qualities have been identified, then to look at a person and determine whether all or most or some of these requirements, characteristics and qualities are present. While the latter approach may adopt too high a standard, and while it may be impossible to find all these characteristics present in one person, it is suggested that this approach will yield the most helpful results, and it is this approach that will be pursued.

It is not intended to elevate the demands of a programme or the requirements of a visitor beyond the attainment of a prospective applicant; nor is it the intention to

¹ See: Dian Joubert: *Sosiologiese Begrippe: 1-50 (supra) p. 51*; George V. Zito: *Sociological Concepts pp 12, 13, 22, 23*

dampen the ardour of a possible visitor by requiring characteristics or qualities in such a person which are impossible of acquirement. What is intended is to set out pointers or indications of what presents themselves as possible requirements of a specialised visitor in the context of the programme.

24.2 REQUIREMENTS CHARACTERISTICS AND QUALITIES

24.2.1 Standing :

It is helpful if the visitor possesses standing in the community, that is, social, professional or commercial reputation or status. This must not import a quality of snobbishness but should be a manifestation of real achievement or merit, so that the ladies may look up to someone who has rank or position in society. If this is stating the position too highly, then let it be said, at the very least, the visitor must possess a character which is unblemished. His character must be without reproach, flawless, spotless and unsullied. This establishes his integrity upon which his vocation as a visitor is founded.

24.2.2 Personality :

The next attribute is of singular importance but it can be misunderstood. Obviously, every human being possesses personality in the sense of those personal or individual qualities that make one person different in nature and act differently from another. Clearly, something more is intended. What is intended is that the visitor must possess a 'forceful' or 'striking' personality but these adjectives are avoided as only a thin line separates them from a 'domineering' personality, which is not intended. The visitor must possess a personality which makes him stand out in the crowd, that makes an onlooker sit up and take notice when he speaks and who possesses abilities, interests and attitudes which make an impact when they are manifested or demonstrated. Arrogance is definitely not included in the attribute.

24.2.3 Education :

The visitor must be an educated person. He must be cultured, literate and trained. He must possess the knowledge, skill, ability and character developed by teaching, training and study. In other words, he must be taught, instructed and schooled in the use of his mind. It is not easy to suggest the learning disciplines that would be helpful to the visitor, although sociology, social work, and psychology come to mind. At the same time, the researcher was skilled in none of these disciplines. He was skilled in the discipline of law, which has been nothing short of helpful in his participation of the visitation programme. The role of education need not, necessarily, be related to a particular educative discipline, but must be related to an ability to use one's mind, to analyse, assess, and evaluate a particular situation, and determine the logical and proper course to be taken.

24.2.4 Experience :

As important as education is to the visitor, just so important is that of experience. The life of a person is made up of actions, events, states and feelings; it consists of skills, practical knowledge, and wisdom gained by observing, doing or living through things. All of the residents can look back over many years of experience, and the visitor must be experientially prepared to identify with these years of experience. It does not follow (particularly in certain areas) that a resident will have no regard to a young, inexperienced person, but when it comes to dealing with the personal problems or difficulties of an elderly resident, experience will play an important and weighty role. The key factor in these situations is identification with the problem or difficulty. It is experience that metes with experience. From his experience, the visitor must identify with the experience of the elderly resident.

24.2.5 Financial independence :

This requirement may not apply in all instances, but it plays an important role in the case under investigation. The researcher is a retired advocate and fulfils the role of specialised visitor in a voluntary capacity. He is not employed by the Ladies Christian Home. While he is subject to the discipline of the Constitution, the Board of Trustees and the General Manager, he is free, financially, from the control and influence of these sources. Accordingly, in the initiation and implementation of the visitation programme, he guided, controlled and governed himself, and was not under the rule and authority of others. Financial independence is emphasized for this reason but also, as will be suggested, for the reason that the visitation programme opens itself to financially independent retired businessmen.

24.2.6 System and organisation :

An early manifestation of the visitation programme was that it had to be operated according to a system, method or plan. Regard being had to the fact that there were a number of residents who had to be regularly and continuously visited in the two main sections of the Home², it was clear that there had to be an orderly arrangement of things and an orderly method of getting them done. Unless the programme was put into working order, some would be visited and others not. The monthly chart³ was developed and put into operation. It is not suggested that this is the only method or plan, but what is suggested is that the specialised visitor must be a person who can operate under the discipline of a system, method or plan. The programme does not lend itself to haphazardness, disorderliness or chance.

² See Chapter Two : *The Nature of the Investigation*

³ See Annexure and Chapter Nineteen : *Occurrences of Visitation*

24.2.7 Analysis :

The specialised visitor must be analytical in two separate spheres. The first relates to the system and organization of the programme of visitation, that is to say, to separate the structure into its various parts, to examine those parts and find out what the essential features of each part are. The residents do not fall into a unified whole. There are two main divisions and within each division there is a multitude of parts. A condition attaches to each part requiring a careful analysis to determine the method and frequency of acts of visitation. The second relates to the problem or difficulty raised by a resident, that is to say, to analyse the problem to devise the most practical and effective means of dealing with the problem or difficulty. A specialised visitor who finds it difficult to determine the precise nature of the problem, is going to find it difficult, if not impossible, to deal with the problem.

24.2.8 Decision :

Indecision, irresolution, wavering and vacillation will be uncomfortable and disagreeable stumbling blocks to a specialised visitor. He must be a person who is able to make up his mind and act with firmness and determination. This does not mean that he must be arbitrary, dictatorial or harsh. Nor does it mean that he must be hasty, impulsive or rash. He must listen to the problem or difficulty, he must analyse it to determine what the real obstacle is, and he must decide on a reasonable and effective course of action.

24.2.9 Independence :

Attention has been given to financial independence⁴. Attention is now given to independence within the wider framework of the programme of specialised visitation. The specialised visitor must be able to think, plan

⁴ See *supra* 'Financial Independence'

and act independently. He is subject to the authority of the Board of Trustees and the General Manager but he acts independently of that authority when he plans, initiates and develops a programme of visitation. He may seek advice and information, and he may test his ideas, but in the implementation of the scheme and in its operation, he is completely independent. The success or failure turns on his initiative and his industry.

24.2.10 Socially minded :

While he is an independent person and while he operates the programme independently, the specialised visitor is not a loner, that is to say, a person who prefers to be alone. He must be socially minded and people orientated. He must be concerned with human beings in their relations with each other. He must like company and be inclined to seek and enjoy companionship and friendly relations even with strangers. An aspirant specialised visitor may be most highly qualified, may possess many of the requirements, characteristics and qualities referred to, and be skilled in the devising of schemes and programmes of visitation, but unless he can put them into practical effect among people, his qualifications, characteristics and skills will be to no avail. Qualifications, characteristics and skills must be balanced against a genial, friendly, companionable and affable nature.

24.2.11 Concern for the aged :

Being socially minded and people orientated goes so far, but not the whole way. Those qualities must be motivated by and arise out of a genuine concern for the elderly. This statement is very far-reaching in its implications. It often means having a concern for someone who has lived the greater part of her life, has little money or education, has no family ties and is in poor health. It often means having a concern for someone

who is becoming increasingly forgetful, who repeats the same statement over and over again, and who is incapable of having a rational conversation. It is a concern which is directed of making old age a more enjoyable time of life. It is a concern which expresses itself in devising ways and means of helping the elderly to lead more active lives and, as a result, feel happier, more useful, and less lonely.

24.2.12 Identification with the aged :

Having a concern for the aged goes so far, but not the whole way. That concern must be translated into a positive and active identification with the elderly. It is not concern at a distance; it is concern which is 'close up'. It involves a close connection, a linking-up with, an association. It is customary to ask after a person's health; it is identification to remember what her ailment is, and to follow it up on as regular a basis as the situation demands. It is entertaining and interesting to converse with an old person who is rational and has a story to tell; it is identification to sit with a person who has nothing to say, or who repeats herself over and over again, or who tells the same thing every time she sees the visitor. Identification involves understanding, acceptance, appreciation; it requires reacting to a person in ways that are appropriate, regard being had to the fact that the specialised visitor's task and role in relation to a resident is to enhance and improve her quality of life.

24.2.13 Humility :

As important and as successful as a person may have been; whatever heights he may have achieved; and whatever qualities he may possess, one thing is required of a specialised visitor, and that is humility. He must have humbleness of mind, he must be lacking in pride, and he must be meek. In all he does, and thinks, and says, he must show a humble

spirit. And this requires no great effort, for, among the aged, humbleness comes easily. One has only to bear in mind that old age is not reserved for those who are old of age. It comes to all who survive the years. Forgetfulness, senility, crippling arthritis are available to all who become elderly. One has only to reverse roles to acquire humility. Who will sit with the specialised visitor when he is in a state of advanced senile dementia?

24.2.14 Sensitivity :

Sensitivity incorporates attributes of susceptibility, impressibility and responsiveness. A person is said to be sensitive who receives impressions readily or is easily affected or influenced. It suggests having, by nature or because of a physical or emotional condition, a specially keen or delicate capacity for feeling or responding to an influence.

The importance of this quality cannot be overemphasized as much is said in a silent room, much is conveyed in an expressionless face, and much is imparted by a plaintive sigh. Atmosphere is a reliable conveyor of private messages. When entering a room, the first expression or utterance can convey an eloquent intimation, and when an appropriate question is asked by the specialised visitor, open a vista of problems or disturbed emotions.

A specialised visitor who is insensitive is at a distinct disadvantage and has considerable leeway to make up before becoming effective in his calling.

24.2.15 Patience :

Patience is demanded in a countless variety of situations, none less than engagements with the elderly. Its encompasses a willingness to put up with all manner of difficulties and troubles, or calmly to endure a

troublesome or unpleasant situation without complaining or losing self-control. With justification, or without, the elderly can give rise to stressful and burdensome situations, which, with justification, and sometimes without, can give rise to reaction and unsavoury response. This often occurs in the family situation and gives rise to conduct which is afterward deeply and bitterly regretted.

It is these situations that issue warnings to specialised visitors, and puts them on their guard. The visitor must, at all times, and in all circumstances, manifest calmness and patient endurance; he must not be heard to complain about the conduct of a resident, nor must he ever lose his self-control.

24.2.16 Sympathy :

The specialised visitor must at all times be sympathetically disposed towards the residents. This embodies kindness, thoughtfulness, tenderness and affection. It manifests itself in a sharing of the resident's sorrow or trouble. It is akin to pity which is a tender or sorrowful feeling or emotion aroused by the suffering, distress, or misfortune of another.

A specialised visitor must be willing and able to demonstrate tenderness and a strong desire to help or protect the resident. There are times when these feelings come easily; there are other times when the attitude and state of mind of the resident makes it more difficult. But difficult or not, the state of mind of the specialised visitor must be such as to be able, in all situations, to demonstrate sympathy towards the resident.

24.2.17 Motivation :

At the heart of many of the qualities already mentioned, as well as those yet to be mentioned, is that of motivation. Unless the specialised visitor is constantly furnished with an incentive or inducement to action, his efforts will be in vain.

He must work towards an end, he must have a direction or purpose, he must be spurred, stimulated, prompted to the ultimate end of providing an enhanced or improved quality of life for the elderly.

Unless he harbours this incentive, this inducement, this stimulus, he no longer pursues the vocation of specialised visitor.

24.2.18 Perception :

The specialised visitor must possess the quality of perception. At all times he must be aware of what is going on in the Home, especially as it affects the residents, either directly or indirectly. He must keep his eyes and ears open; his mind must be quickened; he must be alert; he must be observant. He must keep his hand on the pulse of the Home. Nothing of importance must occur of which he has no knowledge. Without actively interfering in the management or the administration, he must keep abreast of developments. He must keep his ear to the ground so that he becomes the source of information and not the receiver of it. He must be aware of any movements among the residents, and not be told of these movements. He must know the state and condition of resident, and not be informed thereof. Anything that can be perceived, must be perceived; anything observable, must be observed; and anything appreciable, must be appreciated.

The specialised visitor must be a person of understanding, discernment and apprehension.

24.2.19 Conscientiousness :

Conscientiousness embraces two elements both of which are of importance to the specialised visitor. One is a quality of being upright, honourable and honest; being careful to do what one knows is right. In other words, to be controlled by conscience. The other involves a quality

of being particular, painstaking and scrupulous; doing something with sufficient care to make it right. To be otherwise, is to incorporate, to a lesser or greater degree, the qualities of carelessness or negligence, which cannot and must not, characterize the nature of the specialised visitor.

24.2.20 Intelligence :

The specialised visitor must be an intelligent person, in the sense, that he must possess understanding, discernment, sharpness and comprehension. It is doubted if there is any wisdom in attempting a definition of the word 'intelligence'. It may well include the level of a person's ability as measured on an intelligence test. But that is not, necessarily, what is intended. What is intended is something wider and more practical. An elderly person may be rambling in her discourse, bordering, even, on incoherence but she is wanting to say something, to impart some message, to disclose some problem. The specialised visitor must be sufficiently sharp, astute and alert to determine what is being conveyed. Time is usually of the essence and the resident can just as quickly lose her train of thought, as it possessed her to open herself to the specialised visitor.

24.2.21 Spontaneity :

The specialised visitor must possess the ability to act spontaneously. His life conduct and programme must not be rigorously governed by what is planned beforehand. He must be ready and willing to respond to natural impulse or desire. In many respects elderly people are staid in their ways and predictable, and much of their conduct can be anticipated. But situations do present themselves which do not admit of opportunity for advice, guidance or a second opinion, on the part of the specialised visitor. It demands immediate action or reaction. The specialised visitor must possess a sufficient degree of spontaneity to deal with the situation.

24.2.22 Consistency :

As a general principle, the elderly do not adjust easily to change, nor do they readily accept new ideas, or a different way of doing things. They have lived for a long time and they have become used to a certain way of doing things. Moreover, their expectations are that things will continue to be done, as they always have been done. When the specialised visitor puts a programme of visitation into operation in a particular way, the resident will expect him to continue doing things in that way. Innovation may well incorporate improvements but adaption will be difficult for the resident. It is not suggested that innovation must be avoided. By all means let there be innovation (especially if it brings about improvement) but let it be introduced slowly with as little disruption as possible to the existing state of affairs.

24.2.23 Authority :

Authority is used not in the sense of possessing the power to enforce obedience, or the right to command or act. It is used more in the sense of influence, that is, the possession of a personal power which emanates from a person's character or personality or position, whereby he is able to shape the actions of others. It may even mean prestige.

In other words, the specialised visitor must possess authority, influence or prestige whereby he is enabled to produce an effect without using coercion.

24.2.24 Firmness :

This may seem to be contrary to some of the things said above but, even if it is, it is a necessary quality for the specialised visitor to possess. As strange as it may sound, elderly people can be extremely devious and manipulative. It may sound unkind, even cruel, but some elderly people are not averse to plots, schemes, conspiracy or even intrigue to achieve a particular end. Moreover, it is sometimes difficult to unravel the fact from the fantasy and to determine the right from the wrong. Furthermore, an errant judgment can have unfortunate consequences.

Once a plot, scheme or conspiracy has been revealed, the specialised visitor must act with firmness.

24.2.25 Flexibility :

Having dealt with the quality of firmness, one hastens to add the quality of flexibility which is of equal importance. The specialised visitor cannot be too rigid and firm in all circumstances. They must know when to be pliant, tractable and yielding. It is no great achievement to score points or gain victories over old women. And however devious or manipulative they may be, a healthy measure of flexibility may defuse an explosive situation, or at least, avoid confrontation.

24.2.26 Co-operation :

It has already been observed that the specialised visitor enjoys a high degree of independence⁵. This does not excuse him from co-operating with other instances. He must be ready, willing and able to co-operate with the General Manager and the administration.

⁵ See : *Supra : Independence*

They are invaluable sources of information which can be of the greatest assistance to him in his visitation programme. He must be willing to co-operate with the nursing and cleaning personnel. These are people who work in close proximity with the residents and know them well. They can be of practical assistance as well as a source of important information. He must be willing to co-operate with the maintenance staff, as, in the course of the specialised visitation, he is requested to deal with aspects of maintenance. He, in turn, will rely on them.

24.2.27 Spirituality :

This has been listed as the last quality to be possessed by the specialised visitor, as it is the one which is likely to present the greatest problems. Where a person, by conviction and faith, is, by nature, spiritual, he will be able to meet the demands of residents with spiritual or religious problems. Where a person is not, by nature, spiritual, obvious problems present themselves. The specialised visitor is at a distinct disadvantage, but, not necessarily, without hope. He may call on the assistance of spiritually-minded residents but, more probably, will resort to the Bible teacher or a clergyman attached to the Home.

This requirement must not be underestimated or lightly dismissed. There are a number of residents who look to the specialised visitor for spiritual comfort and upliftment. They want to pray with someone, and they want someone to pray for them. While not the best answer, it is open to the specialised visitor to possess a book of prayers which will assist him with part of the problem.

24.3 CONCLUSION

The visitor has been investigated from the point of view of role expectations, role conceptions and the norms regulating role behaviour. It is not suggested that the list is exhaustive; it is not even suggested that the list is final. The visitation programme has been initiated and pursued over a period of two years, and these are some of the requirements, characteristics and qualities that have manifested themselves as necessary in an aspirant visitor. Another programme may reveal that other requirements, characteristics and qualities are necessary. Indeed, the same programme may point in the direction of amendments and variations of the list. The list is advanced as pointing in a particular direction which may indicate the suitability or otherwise of a candidate.

The investigation continues and remains with the visitor. This time to the specialised nature of his vocation.

Chapter 25. SPECIALISED ROLE OF THE VISITOR

25.1 INTRODUCTION

Specialisation is the watchword. The pattern of visitation was examined against the background of specialisation¹. The requirements, characteristics and qualities of a visitor were analysed in the light of specialisation². The role and function of the visitor are now assessed in terms of the demands of specialisation. It will be seen that the specialised visitor is called upon to fulfil a number of roles or functions and that some of these are very exacting in their claims. In considering the specialised role of the visitor, two things must be borne in mind. One is that he is specifically set apart for visitation. While he does execute duties which do not fall within the ambit of visitation, these are of a minor and subsidiary nature. His principal task, indeed, his vocation, is visitation. It is to visitation that he applies his time, skills and talents. He must not permit himself to be diverted or distracted. The specialised visitor must not become so closely associated with the management or administration that he loses sight of the fact that he is separated to the task of specialised visitation.

The second thing that must be borne in mind is that the hallmarks of specialised visitation are regularity and continuity on the part of the specialised visitor. His good faith and genuineness arise out of the fact that his visits, and contact with the residents, are not sporadic and infrequent. Rather, they are characterised by constancy and steadfastness.

¹ See Chapter Nineteen : The 'Special' Nature of Specialised Visitation

² See Chapter Twenty-Four : The Visitor : Requirements, Characteristics and Qualities

25.2 SPECIALISED ROLE

25.2.1 Calling :

The starting point of coming to terms with an understanding of the specialised role of the visitor is that his appointment arises out of a calling or vocation. It may well be an occupation, even employment but it arises out of an inner call to perform the specific function of specialised visitation or fill the position of a specialised visitor. While not necessarily possessing spiritual overtones, it may be compared to a divine call to devote one's life to the ministry. Indeed, it is a form of ministry in the sense that the specialised visitor is set apart to minister to the needs, problems and difficulties of the elderly and to ensure an improved quality of life for them.

The fact of the matter is that this is no run-of-the-mill, commonplace or ordinary employment; it bears with it the characteristic of worthiness and excellence. It is therefore not unexpected that the requirements, characteristics and qualities of a specialised visitor are not easily attainable and that his specialised role embraces aspects which are unusual and exceptional.

25.2.2 Caller :

The primary role and function of the specialised visitor is that of a caller, that is, a person who makes short visits. But they are not short visits which are aimless and without purpose. Indeed, they are directed at a definite end. In fact, they are directed at a number of ends, namely, an initial end, an intermediate end and an ultimate end. The initial end is no

more than getting to know a resident through regular and continuous calls; to ascertain the state of her health and condition of mind; and to slowly build up a healthy and friendly relationship. The intermediate end manifests itself in a deeper relationship marked by a building up of confidence, an engagement in more meaningful conversation, and an expression of problematic thoughts and emotions. The ultimate end is demonstrated in a relationship wherein the specialised visitor can, through his experience, advice and expertise, impart an added dimension to the quality of life of the resident.

25.2.3 Sojourner :

To sojourn is to stay for a time. It may well mean a brief stay but it incorporates the ideas of abiding, of tarrying, of remaining. As far as it concerns the role of the specialised visitor it means a stay which is longer than a call or brief visit. The specialised visitor, as sojourner, tarries awhile; there is duration to his visit. But it is not characterised by duration only; it is also characterised by depth. The specialised visitor and the resident engage in conversation which is deeper and has more substance. Through the medium of calls, the specialised visitor has built-up sufficient confidence and trust that the resident feels free to open up her thoughts, feelings and emotions, and to discuss with the visitor problems and difficulties that she may have encountered. But conversation is not limited to this level. It often proceeds along very ordinary lines; where matters of mutual interest are discussed. Times which were meaningful, but now passed, are often raised by the residents, as are family matters. Often there is little significance in the subject matter itself but it is helpful for future discussions and exchanges to remember the things discussed. No time or opportunity is ever wasted or lost; it is invested in the bank of the memory, and drawn on, with interest, in further and later discussion.

25.2.4 Inquirer :

An inquirer is one who asks; one who tries to find out something by questions. On a deeper level it is one who makes a search for information or knowledge; one who makes an examination of facts. On yet a deeper level an inquirer is one who probes, which implies a search into or a thorough examination or an investigation. A specialised visitor does all of these things; he asks, he finds out what he desires to know by questions. But he goes deeper. He searches for information or knowledge concerning the resident. But even more, he probes by searching into, thoroughly examining, or investigating.

This does not make the specialised visitor a quizzer, or an inquisitor, or a tireless asker of questions. He is, and always remains, a visitor but he seeks to know the person whom he is visiting, and to know about her. In many instances, it is the first time, for a long time, that anybody has shown any interest in the resident, has asked her about her life and her family, or has bothered to inquire who she was or what she was before she was institutionalised.

Moreover, the inquiry is not an end in itself; it is a means to an end. The relevant facts are analysed and stored in the memory. As the occasion arises, some or all of the facts are referred to. This indicates that the specialised visitor has a genuine and lasting interest in the resident, that he can be trusted and relied upon, and that he is a person in whom the resident can have confidence.

An inquirer must not be a busybody, that is, one who is a meddler or a person who pries into the affairs of other people. It all lies in what he asks, and how he asks it; it also lies in the manner in which he uses the information gathered.

25.2.5 Listener :

Listening is an art which is often difficult to cultivate. This is especially so when one or both of the participants to the conversation possesses a strong, forceful personality. One tendency is to talk, and to keep talking, whether or not the other party is interested or is listening. Another tendency, on the part of either or both parties, is to interrupt the other. The effect is to break in upon the person speaking, to hinder, or to stop that person, to disturb the train of thought being expressed, and to separate what has been expressed, from what is yet to be expressed. It is not conducive to listening to what a person is saying or appreciating the thoughts and ideas such person is seeking to convey.

Though not impossible, it is unlikely that the specialised visitor will encounter too many over-talkative residents. But residents do talk. They are not averse to expressing their thoughts, feelings and ideas and it ill-behoves the specialised visitor to fail in trying to hear what the resident is saying, or to neglect in attending closely to what she is expressing for the purpose of hearing what she is trying to convey. His task is to listen attentively and pay attention to the person speaking or to what is being said. In so doing, he manifests his care and concern for, and his interest in, the resident.

25.2.6 Informer :

Despite what has been said, the role and function of the specialised visitor is not that of an impassive, silent observer. He is required to play an active and demonstrative role in supplying the resident with relevant knowledge, facts, or news. Because she is old and because she is institutionalised, does not mean that she is no longer engaged in the

process of living, or that she is no longer part of an active and vibrant society. She stands to be informed of what is going on in her immediate surroundings, in her wider context of the city wherein she lives, of developments occurring in the country and in the world. The emphasis is placed on “relevant knowledge, facts, or news.” It is not suggested that the specialised visitor approach the resident with an encyclopedia full of knowledge or a newspaper full of facts. But he is there to impart relevant information to the resident. He is there to inform her of facts concerning the Home about which she may be unaware; he is there to discuss matters of interest which the resident may have observed on T.V. or read about in the newspaper; and he is there to inspire and animate her by actively involving her in the happenings that are occurring round and about her.

The resident may be old; she may be isolated; and she may be inclined to withdraw herself from society, but she is still alive. It falls within the specialised role of the visitor to keep her active, informed and vigorous.

25.2.7 Advisor :

The specialised visitor may be a lawyer. He may not be. It is of little concern because he does not hold himself out as a lawyer when he advises, even on legal matters. There is little doubt that his advice will be sought on a variety of matters. He is not required to be an expert upon every matter whereupon his advice is sought. What is required of him is honesty and reasonableness. Honesty will enable him to admit that he does not know the answer to the problem put to him and that he is unable to offer his advice thereupon. Reasonableness will enable him to suggest that he, in turn, will seek advice, if the resident so desires, and that he will report back to her.

But reasonableness may operate in another sphere. The specialised visitor is required to be a man of education and experience. He is able to discuss the matter with the resident at length, if needs be. By applying his mind to the problem, and digging deep into his learning and experience, he will, in all probability be able to come up with some reasonable conclusion upon which he will be able to offer his considered opinion and advice.

It may fairly be accepted that few, if any, problems of the residents are of such a complicated nature that the specialised visitor will be unable to offer to the resident reasonable advice. But it does require discussion, careful consideration, application of the mind, and a reasonable conclusion. On this basis he will be able to offer his advice.

25.2.8 Contact :

In whatever light it is considered, the specialised visitor will be seen by the resident as a contact between herself and the administration, General Management and Board of Trustees. In certain circumstances, this is acceptable. Provided the resident is genuine, acting in good faith, and not prompted by ulterior motives, there seems to be no good reason why the specialised visitor should not be a link or contact with some other source. Two factors need to be considered. One is to determine the state of mind and intentions of the resident. This obviously involves discussion with the resident, careful consideration on the part of the specialised visitor, and a reasoned conclusion. The other is that, as a general principle, the visitor should be wary to interfere in the affairs of the administration or the management. But, as an intelligent observer, and as a tactful enquirer, the specialised visitor should, in appropriate circumstances, be able to

approach a fitting agency to deal with the problem. The specialised visitor must not be narrow-minded or stubborn, he must be flexible and objective. As a general rule, it must be said that if there is error, it is better for him to err in favour of the resident, than contrariwise.

25.2.9 Encourager :

One of the objects of the Home is “to provide means whereby . . . encouragement may be given to the residents of the Home”³. The specialised visitor fits comfortably into this objective. It is an important aspect of his specialised role to give courage to the resident. Whatever else this may mean, it certainly includes ‘fearlessness’. Fearless of living and fearless of dying. It also includes increasing the hope or confidence of the resident. The greater part of life may be long-passed, the body may be frail and weak, and the mind may be increasing in its feebleness, but none of these is sufficient to exclude the resident from harbouring desires, and from feeling that these desires will come to pass. The specialised visitor must consider this as part of his specialised role. The resident must never be left to feel that she can no longer look forward to something with expectation.

The specialised role of the specialised visitor is to urge on the resident, to offer her expectation, anticipation and optimism. Courage implies moral strength that enables the resident to face trouble or pain steadily and without showing fear.

25.2.10 Strengthenener :

The specialised role of the specialised visitor goes further. Moral strength is one thing, physical and mental strength is another. It is the role of the visitor to make the resident stronger; to create and build-up the quality or

³ *The Ladies Christian Home Constitution para. 3.3*

condition of being strong, powerful and vigorous. It involves the reinforcement or fortification of someone who is essentially weak of body and, possibly, feeble of mind. This role has particular significance where the resident is sick or ailing, is depressed or tired, or is on the path to increasing forgetfulness.

25.2.11 Comforter :

A comforter may be said to be a person that gives comfort. That sense of the word is not excluded but it is given a wider meaning. In Biblical terms it is akin to a derivative of the word *parakletos*, which means literally 'to call beside'. The verb from which it is derived has been interpreted both actively and passively; actively as meaning one who stands by and encourages; passively as meaning one called to stand by someone else, as a friend⁴.

The specialised visitor is certainly one that gives comfort to the resident. But he is more. He is someone who stands by the resident as a friend, to offer comfort, solace and strength. The significance of the term lies in the position or stance taken up by the comforter; he is at the side of the resident, a constant, abiding companion who is there, whenever needed by the resident.

25.2.12 Uplifter :

Upliftment relates to the emotional or spiritual state of the resident. The spiritual state will be dealt with under a separate head⁵. In this paragraph comment will be confined to the emotional state. The specialised visitor must, from time to time, expect to encounter a resident who is tired, depressed or weepy. Emotion is an expression of feeling and is

⁴ *The New Bible Dictionary published by Inter-Varsity Press (1962) See : 'Advocate'*

⁵ *See below : Faith*

experienced by everybody. The elderly are not excluded. They may experience positive emotions such as love, joy and hope. Negative emotions such as anxiety, fear, despair, sadness or depression, make the resident unhappy or dissatisfied.

The specialised visitor must help the resident to cope with the negative emotions; he must try and uplift them in order to be happy and so enjoy an improved quality of life.

The specialised visitor will, from time to time, encounter residents who harbour anxieties over the smallest of problems. Anxiety is an emotional state of fearfulness, apprehension, a feeling of impending disaster without reasonable explanation. The resident cannot control her feelings and, at the same time, will agree that there is no logical reason for feeling the way she does. The specialised visitor must intervene and employ his skills to uplift and encourage her.

A difficult situation presents itself to the specialised visitor where he encounters a resident who has become apathetic, whose emotions are dulled, to whom nothing seems to matter, who is completely indifferent to circumstances and events occurring round and about her, who does not have strong feeling of any type. She stands to be uplifted and it is the specialised visitor who must accomplish this end.

Other emotions such as depression or anger could be dealt with in some detail, but the point is made. It falls to the lot of the specialised visitor to be an uplifter.

25.2.13 Bearer of hope :

When a resident reaches the age of eighty or ninety and engages in a backward look, she can be excused for not harbouring hope. But she is not yet dead. And whatever may be the duration thereof, the rest of her

life lies before her. She has opportunity to dream, to imagine, to think and to plan. And for as long as she has these opportunities, she has hope. This hope may be faint, or trembling, or even feeble, but it embraces a forward look; it embraces a future; and it gives the resident a reason to live and a purpose for life. Where a resident has lost hope and is incapable of envisaging the future, she becomes hopeless, desperate and despairing.

It is the role and function of the specialised visitor to be a bearer of hope and a creator of visions. Where it has been lost, he must recreate a future and within that future he must give rise to expectations, and within those expectations, the anticipation and optimism that they will be achieved.

He is not there to obliterate the past or even try to encourage the resident to refrain from the backward look. He is there to create a balance. Just as there is a certainty concerning the things of the past, so there must be a certainty concerning the things of the future.

25.2.14 Bringer of peace :

Peace is the state of being calm, quiet, and free from disturbance. It is the state of mind and heart that one would expect to pervade a group of elderly ladies. And in many instances, this is the case. In many rooms one finds a quietness and a calm, a serenity. But not so in all rooms. Indeed, on any one day, during a number of visits, one discovers stress, sadness, pain; a disturbance of something deep within. An uncomfortable restlessness. One cannot leave the resident in that state of mind and heart.

The specialised visitor must look deep within himself, draw on the wealth of his wisdom, experience, and spiritual resources, and impart to the resident by way of word, touch, or quiet stillness, a peace which is positive and real. A peace which removes the distress and restlessness, and instills a new frame of mind and a more positive approach to the situation wherein the resident finds herself.

As demanding as it may be, the specialised visitor must see, within his role and function, the ability to impart peace.

25.2.15 Instiller of faith :

Faith cannot be avoided; nor must the specialised visitor try to avoid it. Indeed, his function and role is to be an instiller of faith. In one sense, faith is to believe without the necessity of proof. In a more specific sense, faith is a belief in God, or religion, or spiritual things. Where he instills faith in these senses of the word, the specialised visitor stands on firm constitutional ground, because one of the objects of the Home is:-

“.... to provide as far as is reasonably possible for the presentation of the gospel of salvation through faith in the Lord Jesus Christ.”⁶.

The sensitive and intelligent specialised visitor reads the constitutional objective with care and does not fail to give meaning to the words “as far as is reasonably possible.”

There are many residents who possess a deep and convicted faith in Jesus Christ. To them it is not difficult to be an instiller of faith. They are keenly responsive to things spiritual and welcome words and promises of scripture. Nor are they averse to sharing in prayer. Indeed, they welcome it.

Others are not so spiritually active or responsive. The specialised visitor must not be hasty to give effect to the constitutional objective and attempt to be an instiller of faith where it is not “reasonably possible”.

⁶ *The Ladies Christian Home Constitution para. 3.4*

The watchwords are “sensitivity and intelligence”⁷. Where he can offer spiritual comfort and strength, he must do so. Where it is inopportune so to do, he must refrain until the right moment presents itself.

25.3 CONCLUSION

The role and function of the specialised visitor have been analysed and assessed. It is manifestly clear that the demands of specialization are exacting but not beyond those who are called to the task. There are, however, spheres which he must avoid, and it is to these matters that the investigation now moves.

⁷ See Chapter Twenty-Four : “Sensitivity” and “Intelligence”

Chapter 26. SPHERES OF AVOIDANCE BY THE VISITOR

26.1 INTRODUCTION

The specialised visitor enjoys a good deal of independence. He is financially independent in the sense that he is not employed by the institution and is therefore not subject to the usual restraints that govern the employer-employee relationship¹. But even if he was employed by the institution, and was subject to the employer-employee restraints, he still acts independently within the context and framework of the visitation programme². But over and above any restrictions and confinements that may arise out of his being subject to the authority of the Board of Trustees and the General Manager, there are, by the very nature of the calling to be a specialised visitor, certain spheres which he should seek to avoid as engagement in these spheres can only act to the detriment of the visitation programme.

In other words, the programme itself places upon the specialised visitor, certain circumscriptions and limits which he ignores at his peril and which can place the entire visitation programme at risk.

26.2 SPHERES OF AVOIDANCE

26.2.1 Confrontation :

There are times when the resident is manifestly in error, when, by her attitude or conduct, she is clearly in the wrong, and she stands to be reprimanded and rebuked. She has created for herself a situation which invites confrontation, or gives rise to confrontation.

¹ See Chapter Twenty-Four : *Financial Independence*

² See Chapter Twenty-Four : *Independence*

Confrontation, by definition, implies a meeting, face to face, or, to stand against, or, to oppose³; it may even give rise to a threatening, menacing or intimidating attitude. Two situations stand to be considered. One is confrontation insofar as it concerns the resident and her family. The second relates confrontation between the resident and the specialised visitor.

Both of these situations will be considered during the course of the discussion which follows. Before proceeding with such discussion, however, it is proposed to make certain observations of a general nature concerning confrontation.

Confrontation invariably arises out of, or leads to, argument. Argument, in turn, leads to aggravation, annoyance and anger. Each of these is sufficient reason to avoid confrontation. But the end result is more compelling. It leads to avoidance and alienation. This frequently occurs in the relationship between members of the family and the resident. What often starts off as a fairly innocuous argument leads confrontation and this, by way of a variety of means, leads to anger which, when fully developed, leads to avoidance and (unless one party yields) ultimately to alienation. It is either the daughter who refuses to talk to her mother, or a mother who refuses to talk to her daughter.

Whatever the situation may be as it affects the resident and her family, a similar situation cannot be allowed to develop between the specialised visitor and the resident. Whereas specialised visitation is characterized by continuity and regularity directed at the end of an enhanced quality of life for the resident, confrontation is characterized by a number of emotions the end result whereof is estrangement and isolation of the resident.

³ *The World Book Dictionary (Published by The World Book Encyclopedia 1975) see : 'Confront'*

Where the possibility of confrontation between the resident and the specialised visitor arises, the visitor must use all his skills and competence to defuse the situation so that the objective of specialised visitation can be achieved.

26.2.2 Personal Involvement :

By the very nature of specialised visitation, and more particularly, the characteristic of continuity and regularity, a certain amount of personal involvement must occur between the specialised visitor and the resident. This is acceptable and to be encouraged.

The sphere of avoidance to which attention is drawn relates to two specific aspects of personal involvement. The first aspect is that of personal problems. Obviously, the specialised visitor must be able to assist and advise a resident on her personal problems. But he must do so objectively. He must not become subjectively involved. It is the resident's personal problem; not his. He may possess all the requirements, characteristics and qualities of a specialised visitor⁴, and he may be able adequately to fulfil the specialised role of the visitor⁵, but he must not become personally involved with the problem.

The second aspect is that of giving personal undertakings. The specialised visitor must always bear in mind that he cannot and must not lightly give personal undertakings. Indeed, regard being had to all the characteristics and qualities required of him, as specialised visitor⁶, he must not, on any level become involved with the resident. With the

⁴ *Chapter Twenty-Four : The Visitor : Requirements, Characteristics and Qualities*

⁵ *Chapter Twenty-Five : The Visitor : Specialised Role*

⁶ *See footnote 4 above*

passage of time, and with regular and continuous visitation, a resident may rely upon him as the panacea of all ills. This being the case, any manner of personal undertaking given by a specialised visitor, will be relied upon, to the possible disappointment and distress of the resident. Should a particular need present itself, personal undertakings must be avoided. Rather the specialised visitor must hear out the resident, and see if he can reasonably provide an answer, without giving any personal undertakings.

26.2.3 Promises :

Likewise the matter of promises. Promises imply fulfilment. Once a promise is made by the specialised visitor it must be capable of fulfilment and it must be fulfilled. Save in the situation where the mental state of the resident is such that she forgets that a promise has been made, the resident is not likely easily to forget a promise made by the specialised visitor. She may not hold the visitor to his promise in the sense that she might not again mention the matter. But in her estimation, he has disappointed her and let her down. Moreover, he is not to be trusted.

In similar fashion, there is the promise which is capable of fulfilment but which is forgotten by the specialised visitor. The result is similar. The specialised visitor cannot allow himself the luxury of forgetfulness where he has made a promise to a resident.

26.2.4 Interference :

The specialised visitor, in the operation of the programme of specialised visitation, works in close proximity to the general management, the administration, the nursing and maintenance staff. While he may act independently of them, this does not detract from the proximity which

exists between him and them, nor does it detract from the reliance he must place upon them in order properly to fulfil his calling.

But just as he operates in close proximity to these offices, so he operates in close proximity to the residents. So close, in fact, that he may be tempted, by virtue of manifestations of this closeness, to interfere with the general management, the administration, and the nursing and maintenance staffs. But he must not do so. He does form part of the general management, the administration, or the nursing and maintenance staffs. Still less, is he entitled to question their respective areas of authority, or to interfere therein.

Within the compass of his separated operation, and in particular, in connection with observations he may make, or problems that may arise, or disclosures that are made to him, or requests and complaints that are addressed to him, he may, directly or indirectly, head-on or obliquely, openly or artfully, raise some, or all, or part of the matters, with the view to obtaining information, guidance or assistance. But he must withhold himself from interfering with them, or undermining their authority.

The cause of the programme of specialised visitation is best served if there is an amicable co-operation between the specialised visitor and the various offices, rather than conflict, hostility and unfriendliness.

26.2.5 Family go-between:

Just as the general management, the administration, the various staffs, and the specialised visitor play an important role in the life and experience of the resident, so the family also makes its contribution⁷.

⁷ See *Chapters Thirteen, Fourteen and Fifteen*

But there are two areas in regard to the relationship between the resident and her family which constitute spheres of avoidance. One relates to differences which may arise between the family and the resident.

These differences do arise, often, quite frequently. At times it is difficult to determine the precise nature of the difference, as the story related to the authorities by the resident differs widely from the story related by the family. The fact of the matter is that there is a difference (or there are differences) between the resident and the family, whatever the nature of the difference (or differences) may be.

The specialised visitor must not take sides. If he sides with the family, he will incur the displeasure of the resident. If he sides with the resident, he will incur the displeasure of the family. Indeed, he must not become embroiled in the conflict. He must distance himself, not from the resident, or the family, but from the differences between the resident and the family. And it must be a total and complete dissociation. He must continue to visit the resident, but he must not allow the differences between the parties to be raised. There is an exception to this general role. If there is an opportunity to affect a reconciliation between the resident and her family, he must avail himself of this opportunity but it must be unconditional and it must have no reference to the differences.

The second relates to requests (or demands) on the part of the family or the resident. The specialised visitor must always bear in mind that he is not the General Manager, nor is he part of the administration. Still less is he the bearer of requests or demands from the party concerned to the management or the administration. Where a party has a request or a demand, it must be addressed to the correct source. In this regard, the specialised visitor must not vacillate. He must, at the very outset of the request or demand, make his standpoint clear and not attempt to act as a 'middle-man'.

26.2.6 Legal Advisor :

It is part of the specialised role of the specialised visitor that he acts as an advisor⁸. But not a legal advisor. He may be skilled in the law but his task is that of a specialised visitor, and not an attorney. Where he purports to give legal advice on an authoritative basis, he launches into troubled waters, and may well find himself in difficulties.

As has been observed, in giving advice, he must act with honesty and reasonableness⁹. Legal advice falls within the ambit of expertise of an attorney. It may well be that the resident cannot afford the services of an attorney, in which case the matter must be referred to the general management for action, as they best see fit. But the specialised visitor will be ill-advised to assume the role of legal advisor, especially where the consequences may be grave. At the same time, the resident must not be left to bear the burden of an unsolved legal problem.

26.2.7 Impatience :

Ministering to the elderly can be a difficult and frustrating task. It can drive the most well-meaning specialised visitor to exasperation. It must always be remembered that most of the residents have lived a very long time. They are set in their ways and do not take kindly to change. They are often stubborn and unyielding. They are forgetful and must be told the same thing over and over again. They are forever losing their bags, their walking-sticks, and their keys. They can be, and often are, manipulative. They can turn on the tears when it suits them, and they can adjust their behaviour so as to obtain a favourable response.

⁸ See Chapter Twenty-Five : Advisor

⁹ See footnote 8 above

Patience calls for endurance, calmness, composure and forbearance. It implies self-control, even when greatly tried or provoked. Many instances will present themselves which may justify the specialised visitor in losing his calmness, or his self-control. In other words, to become impatient. But he cannot and he must not. Impatience must at all times, and in all circumstances, be avoided.

26.2.8 Favouritism :

Some residents easily endear themselves to all they meet, and especially to the specialised visitor. He likes to visit them and they are pleasant company. He invites them to his office. They drink tea together. Other residents conduct themselves in a manner, or adopt an attitude, which makes it a hardship to visit them. They readily makes themselves people to be avoided. But that is not the way the specialised visitation programme works.

All are elderly. All are the targets of the programme. All, potentially, harbour problems and difficulties. All, at some time or another, need someone to whom they can pour out their hearts, can look to for encouragement, strength and comfort, and can find hope, peace and faith¹⁰.

If the specialised visitation programme holds out benefits and advantages (and an enhanced quality of life) to the elderly, and it is argued that it does, then it must be for all, pleasant or unpleasant, and not just the favoured few.

In the premises, it behoves the specialised visitor to avoid any form of favouritism, and apply, in equal measure, the visitation programme to all the residents.

¹⁰ See Chapter Twenty-Five : *The Visitor : Specialised Role*

26.2.9 Unconstitutional Conduct :

Rightly or wrongly, the specialised visitor may consider himself completely independent and free from the control of the management and administration, and set apart entirely to the task of specialised visitation. But he can never contend that he is not bound by the terms and provisions of the Constitution. The Constitution may not make any mention of the appointment of a specialised visitor or a programme of specialised visitation, but that does not mean that he is free to disregard the contents and spirit of the Missions Statement set out in the Constitution¹¹, or the objects of the Home as contained therein¹².

He must recognize that in all its endeavours, the Home is motivated by a love for God,

“ . . . and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares,”

and that the programme of specialised visitation must be consistent with these high ideals. He must recognize that one of the objects of the Home is,

“ . . . to provide means whereby . . . encouragement may be given to residents of the Home . . . ”

and that such must,

“be consistent with and supportive of the Mission Statement and in keeping with Evangelical, Protestant and non-sectarian principles . . . ”

¹¹ *The Ladies Christian Home Constitution para. 2*

¹² *The Ladies Christian Home Constitution para. 3*

and that the programme of specialised visitation must accord with this object.

However wide may be the ambit of his freedom and independence, and however flexible he may be in the application and development of the visitation programme, the specialised visitor must ensure that he does not conduct himself unconstitutionally.

26.2.10 Nuisance :

Regularity and continuity are the dominant features of the visitation programme. This does not mean that license is given to the specialised visitor to make a nuisance of himself in the sense of imposing himself upon the resident or overstaying his welcome or interrupting the resident when she is otherwise engaged. The specialised visitor must be sensitive. This is one of the requirements and qualities of a specialised visitor¹³.

It rarely occurs that a resident does not want to see the specialised visitor but there are times when visitation is inconvenient, as when a nurse is attending to the resident, or when other people are present, or when the resident is expecting someone. She may be resting, or meditating, or praying. She may be engaged in her devotions. She may not feel well. She may not want to be disturbed. She may not want to talk. There are all manner of reasons why the resident may not want to receive visitors.

Visitation is not a right. It is a privilege. The specialised visitor visits a resident with her permission and at her pleasure. She is unlikely to refuse him entry, but she may make her attitude clear in some other manner. The specialised visitor must be responsive to this attitude.

¹³ See *Chapter Twenty-Four : Sensitivity*

Indeed, there is wisdom in intending any proposed visit to be no more than a call¹⁴. This means that after the exchange of pleasantries, the visitor can excuse himself without causing offence, or without being a nuisance. If, however, the reception is cordial and there are no indications that the visitor is unwelcome, the call may be transformed into a sojourn¹⁵. In so doing, he will achieve the purpose of his act of visitation, and not be a nuisance.

26.3 CONCLUSION

Permission to conduct a specialised visitation programme does not bear with it the right for the visitor to act in whatever manner he pleases. Apart from any actual or implied restrictions, there are certain circumscriptions and limitations which arise out of the programme itself and which it ill-behoves the visitor to disregard. The attention remains with the visitor but in the next chapter it is directed at 'extra visitational matters'.

¹⁴ See Chapter Twenty-Five : 'Caller'

¹⁵ See Chapter Twenty-Five : 'Sojourner'

Chapter 27. EXTRA-VISITATIONAL MATTERS ON THE PART OF THE VISITOR

27.1 INTRODUCTION

Reference is made to certain observations which have been made in relation to the visitor and the matter of visitation. It has been observed that the visitor needs to meet a number of requirements, characteristics and qualities, some of which are difficult of attainment¹. It has also been observed that the visitor is required to fulfil a highly specialised role, some aspects of which are very exacting in their demands². Thirdly, as to the matter of visitation, the observation has been made that the visitor is specifically set apart for visitation³.

Before dealing with the question raised in the next paragraph, it is needful to discuss an important aspect. Much of what is discussed in this paragraph and the next has particular reference to the Ladies Christian Home and arises out of the fact that the researcher is a lawyer and the Chairman of the Board of Trustees. Accordingly, the matters being dealt with may have special reference to the Ladies Christian Home, or to the legal skills of the researcher, and not have general application i.e. to other institutions for the aged. For instance, Paragraph 27.2.1 may well have general application, whereas Paragraphs 27.2.2 to 27.2.10 will, more likely, have specific application to the situation pertaining to the Ladies Christian Home. Therefore, the comments must be read strictly within the context of the Ladies Christian Home, and not in a wider context.

The question arises as to whether the skills of a person who possesses a number of these attributes would not be better employed if they were deployed over a wider front, that is to say, within the context and framework of the management and administration. There is merit in the argument which flows from an affirmative

¹ See Chapter Twenty-Four : *The Visitor : Requirements, Characteristics and Qualities*

² See Chapter Twenty-Five : *The Visitor : Specialised Role*

³ See Chapter Twenty-Five : *'Introduction' and 'Calling'*

answer to this question but three things need to be considered. The first is that the success of the specialised programme of visitation presupposes that the visitor be specifically set apart for visitation and that in the execution of his duties, he enjoys a considerable degree of independence, that is, that he is not part of, or answerable to, the management or administration. Accordingly, were the visitor to be incorporated into the management or administration as an adjunct to his role of specialised visitor, the nature and effect of the visitation programme would be considerably altered, and as a result, would be weakened in character and force. It is argued that the suggested move would redound to the detriment of the programme of visitation. The second is that the appointment of a specialised visitor who is specifically set apart for the task of visitation considerably alleviates the burden resting upon an already overloaded management and administration. It must be remembered that, in the absence of the appointment of a specialised visitor, the task of visitation falls to the management and administration, to cope in the best way possible. The third relates to the independent nature of the specialised visitor.

The independent nature of the specialised visitor accords to him an objectivity which permits him to fulfil certain extra-visitatorial roles. These roles do not affect his independence; they do not detract from the effectiveness of the programme of specialised visitation; and they would not be open to him to pursue if he were part of the management or administration. These extra-visitatorial matters will now be considered.

27.2 EXTRA-VISITATIONAL MATTERS

27.2.1 Objective Viewpoint :

In the experience of the researcher, the management and administration frequently encounter problems which do not admit of an easy answer. One way of dealing with these problems is to refer them to the Board of Trustees. The Board meets approximately once every two months and the

problems encountered often require immediate or speedy resolution. It is, of course, possible to convene an additional meeting of the Board, or, at least, to communicate with each Trustee telephonically. This is cumbersome. It is also time-consuming.

Another way of dealing with the problems is to refer them to the specialised visitor, in a non-visitational capacity. He is required to be a person of education and experience. He is also a person who is at home in the sphere of dealing with problems. Moreover, he is independent; he is not involved, and he is unbiased. He can hear the problem, analyse it, if needs be, debate it, and give his considered objective viewpoint.

His independence is recognized, his objectivity is recognized, and the expression of his objective opinion can have no bearing, or detrimental effect, on the visitation programme. He fulfils a completely extra-visitational role.

27.2.2 Disciplinary proceedings :

The new political dispensation has introduced all manner of changes in labour relations⁴. Not the least of these changes relates to the need for disciplinary proceedings in appropriate circumstances. The fact that the researcher is an experienced lawyer places him in advantageous position to adjudicate in disciplinary proceedings. But provided the specialised visitor is capable of being objective, is acquainted with the requirements of the law, and is able to apply fairness, justice and equity to the situation, the fact that he is not a lawyer, should not disqualify him from adjudicating in disciplinary proceeding.

⁴ See for instance : *Labour Relations Act No 66 of 1995*

The staff of the Ladies Christian Home is reasonably small⁵, the problems are minimal and uncomplicated, but when labour matters, involving disciplinary proceedings present themselves, it is invariably taxing on the management. So much so, that before the appointment of the specialised visitor, resort was had to outside professional sources to deal with these matters. This has changed.

Before proceeding with the matter under discussion, it is necessary to stress three things. The first is that in the operation of the visitation programme, the specialised visitor is in regular and close contact with the management and administration. They are able to observe him, assess his abilities, and determine his qualities of fairness and objectivity.

Secondly, and in like manner, the specialised visitor comes into regular, and reasonably close contact with the employees. They too, are able to observe him, assess his abilities, and form an opinion on his qualities of fairness and equity.

Thirdly, the specialised visitor is bound to observe the provisions of the Constitution which determines :-

“It (the Home) believes that the welfare and security of the elderly, infirm and needy are best served by staff members whose own rights, dignity, and well-being are recognized, respected and advanced.”⁶

With the appointment of the researcher as specialised visitor, he has assumed the role of arbiter in disciplinary matters. Hitherto, this has been to the satisfaction of the management and the staff members.

Moreover, the exercise of this extra-visitatorial role, has not, in any way, affected the visitation programme adversely.

⁵ See Chapter Three : Appointed Structure (Permanent)

⁶ The Ladies Christian Home Constitution para. 2

27.2.3 Staff members and trade unions :

This is a matter associated with the one just discussed. With the introduction of legislation bringing about important changes relating to employees and trade unions, the ‘rights, dignity and well-being’ of staff members has come under the spotlight.

As one would expect, tension between management and staff members, and management and the trade unions has arisen. Moreover, attitudes on the part of certain staff members, and on the part of management has changed. What is required is someone who can act as the middleman or mediator. On the one side, one has the active involvement of management, and on the other side, the active involvement of staff members or the trade unions.

The management cannot rely on its own judgment. It is subjectively involved. What is required is a cool head, a calm disposition, and a keen perception for fairness and justice.

This, the specialised visitor is able to offer in any advice or guidance he is asked to give in regard to staff and trade union matters, without jeopardizing or compromising the visitation programme.

27.2.4 Management :

Without becoming identified with or engaged in management, the advice and guidance of the specialised visitor is sometimes sought on aspects of management. Again, reference is made to his independence and

objectivity. He is not required to become part of management, nor does he, necessarily, have to support management. What is sought of him is his advice and guidance. He is required to offer his opinion in an honest and forthright manner. This advice may be accepted or rejected. He does not offer an instruction or a directive. That is not his role.

Such advice and guidance cannot reflect upon or affect the programme of specialised visitation.

27.2.5 Administration :

Likewise with the administration. The specialised visitor relies upon the advice and guidance of the administration in relation to the state of health of the residents and their surrounding circumstances. But he does not thereby become part of the administration. He relies on their advice and guidance in regard to the affairs and administration of the Home. In so doing, he does not become so closely associated with the administration that he can be regarded as part of it. In the discharge of his duties as specialised visitation programme, he works in close proximity with the administration but never becomes part of it.

In similar fashion, the administration seeks the advice and guidance on matters of administration. As with management, it is his advice and guidance which is being sought and no more, or no less, than his honest and considered opinion is expected. It is for the administration to decide whether or not to accept it. He acts in an extra visitational role, and in such a manner, that his conduct cannot affect or operate to the detriment of the visitational programme.

27.2.6 Trustees :

The specialised visitor is a trustee and Chairman of the Board of Trustees. Although it is with the permission and authority of the Board of Trustees that he acts as specialised visitor, his function and role as Trustee and Chairman of the Board of Trustees are divorced from his function and role as specialised visitor. He acts as Trustee, as Chairman of the Board, and attends Board meetings in an extra-visitational capacity. In reporting to the Board on visitational matters, he acts, not as Chairman or as Trustee, but as specialised visitor.

His extra-visitational role as Chairman and Trustee does affect the visitational programme in the sense that it gives credence, respect and authority to the specialised visitor and the visitational programme. Indeed, it is suggested that wherever an appointment to a specialised visitational position is made, that specialised visitor should serve on the governing authority of the institution. The specialised visitor and the visitational programme should carry with them the stamp of approval and authority of both the management and the Board of Trustees.

27.2.7 Writing letters :

Another extra-visitational role played by the specialised visitor relates to a class of letters written on behalf of the Home, namely, letters of appreciation for gifts received. The run-of-the-mill business letters are normally handled by the administration in the exercise of its ordinary course of business.

The institution relies to a certain degree on gifts received, generally speaking, money from companies, trusts and other well-meaning instances. The institution fosters and encourages this sort of giving. Moreover, when such gifts are received it behoves the institution to respond timeously and adequately.

Timeousness reflects itself in a letter written soon after the gift is received. Adequateness reflects itself in a letter which is well written, expresses gratitude and appreciation in a genuine and sincere manner, and bears the signatures of the Chairman of the Board and the General Manager.

The specialised visitor fulfils this extra-visitational role in drafting the letters and signing them, not as specialised visitor, but as Chairman of the Board of Trustees. This role has no effect whatsoever on the visitational programme, cannot and does not harm it, and has no connection with it.

27.2.8 Services of worship :

A service of worship which lasts for a half an hour is held on every Tuesday morning. On the last Tuesday of the month the sacrament of communion is administered. If the condition of the resident permits, attendance is compulsory. The services are conducted by clergyman representing one of the various denominations which are constitutionally associated with the Home⁷.

It happens, from time to time, that the clergyman appointed to conduct the service, for one reason or another, fails to present himself. The task then falls to the specialist visitor to conduct the service in an extra-visitational capacity. Strictly speaking it is extra-visitational in the sense that it does not form part of the visitational programme. However, on a wide understanding of the nature and effect of the programme, it could be argued that the conducting of a service of worship is not an extra-visitational role. The specialised visitor is meeting with the residents, albeit not individually; he is dealing with spiritual matters, which may well constitute a need in the life of the resident; and he is communicating with the residents on an acceptable and critical level.

⁷ See Chapter Three : *Appointed Structure (Part-time)* and Chapter Four : *Appointed Persons (Part-time)*

But even if it is a extra-visitational role, it does not disturb or harm the visitational programme, or his role and function as specialised visitor.

27.2.9 Memorial services :

Akin to services of worship, the specialised visitor is occasionally called upon to conduct a memorial service, in an extra-visitational capacity. A memorial service is an act of worship at which tribute is paid to the life and memory of a resident who has died in the Home. It is usually conducted by a clergyman.

In one sense it must be regarded as extra-visitational as it falls outside the ambit of the programme. In another sense it may be regarded as a culmination of the programme. In most instances where the specialised visitor is asked to conduct the memorial service, he has built up a special relationship with the resident, he has come to know her through regular and continuous acts of visitation, and he is in the privileged position to be able to address the congregation on her life and memory.

But in whatever light the role is viewed, it is certainly not contrary to the end at which the specialised visitation programme is directed.

27.2.10 Legal obligations :

In the many years of its existence the Home has had to adjust itself to manifold changes. These changes have increased with the passage of time. The management must constantly ask itself as to what precisely are its legal obligations, and more pressingly, as to whether it is fully complying with the legal obligations imposed upon it.

It is unnecessary to detail either with the changes or the legal obligations; indeed, it would be impossible to do so. The matter is accordingly dealt with in principle.

In her demanding programme, the General Manager is frequently in receipt of documents which indicate a change in official policy and require the management either to complete certain documentation or to comply with certain legal obligations. There are times when she is unsure as to the manner in which she must conduct herself or what legal obligations are being imposed upon her.

In the exercise of her judgment she refers these matters to the specialised visitor in an extra-visitation capacity, to peruse the documentation, or consider the problem, and express his opinion on the legal obligations, if any, which are being imposed upon her.

In responding, the specialised visitor does not act as an attorney or legal advisor. He considers the documentation and offers his opinion, or he acts on the advices given to him, and to the best of his ability he suggests, advises or carries out the task entrusted to him. He does not purport to impose his views upon the management who is free to accept or reject his suggestions, advices or the manner in which he has executed the task.

He never usurps the role of the General Manager or becomes involved in the management. He merely expresses his view on what the legal obligations appear to be. It is suggested that in conducting himself in this manner he neither compromises or endangers the programme of specialised visitation.

27.3 CONCLUSION

It has been observed that the function and role of the specialised visitor is not confined to the programme of specialised visitation. It goes much wider. In a number of respects he is required to consider certain extra-visitational matters. It is contended that, in so conducting himself, he neither compromises nor opens the programme of specialised to criticism or suspicion. Attention is now drawn to the visitor in relation to the management and the Board of Trustees.

Chapter 28. THE VISITOR IN RELATION TO THE MANAGEMENT AND BOARD OF TRUSTEES

28.1 INTRODUCTION

The visitor has been investigated substantively in a number of differing contexts. He has been examined in the context of the requirements, characteristics and qualities that are expected of a visitor¹. He has been considered in the context of the specialised role to be filled by the visitor². He has been analysed in the context of the spheres he is required to avoid³. He has been assessed in the context of the extra-visitatorial matters in which he must participate⁴.

In each of the investigations the visitor is considered either in relation to the resident or to the programme of visitation. Nowhere is he examined substantively in relation to the management or the Board of Trustees. In a number of places the subject has been touched upon incidentally⁵, but it is a matter of some importance and needs some degree of investigation. First, the visitor will be investigated in relation to the management; then, in relation to the Board of Trustees; finally conclusions will be drawn.

It is manifestly apparent that this chapter has specific application to the situation which prevails at the Ladies Christian Home, where the researcher fulfils the role of specialised visitor and the Chairman of the Board of Trustees. It does not have general application and must not be read as having application beyond that which pertains to the Ladies Christian Home.

¹ See Chapter Twenty-Five : *The Visitor : Requirements, Characteristics and Qualities*

² See Chapter Twenty-five : *The Visitor : Specialised Role*

³ See Chapter Twenty-Six : *The Visitor : Spheres of Avoidance*

⁴ See Chapter Twenty-Seven : *The Visitor : Extra –Visitatorial Matters*

⁵ See Chapter Twenty-Four : *“Financial Independence”*; *“Independence”*; *“Co-operation”*, and Chapter Twenty-Six *“Interference”*

28.2 VISITOR AND MANAGEMENT

28.2.1 Background :

An appointment of a General Manager of the Ladies Christian Home was first made on the 4 February 1992. Prior to that date the day-to-day management of the affairs of the Home fell to the lot of the Secretary who served in a voluntary and honorary capacity. The ultimate authority and control of the Home was in the hands of the Board of Trustees and the Board of Management as they existed under the Constitution which operated at that time⁶.

In 1994 the Board of Trustees approved a new Constitution. It authorized the Board of Trustees to appoint a General Manager for the purpose of managing the day-to-day affairs of the Home. It also determined the function, authority and duties of the General Manager⁷.

In 1994 also the researcher was appointed Chairman of the Board of Trustees. This marked the commencement of a regular and close contact between the researcher and the General Manager.

This was particularly so immediately before the (then) monthly meetings of the Board of Trustees. In preparation for the meetings, the researcher sought to be briefed on the situation which pertained to the Home. He discussed the matter with the General Manager, usually by way of telephonic communication. Problems arose from time to time and these were also discussed, occasionally by way of face-to-face contact, but more usually, telephonically.

⁶ For the purposes of this chapter, and the thesis as a whole, it is considered unnecessary to elaborate on the previous Constitution, or the structure which operated in terms of it. The previous Constitution is referred to by way of historical background and has no relevance to the subject-matter under discussion or the investigation being undertaken.

⁷ The Ladies Christian Home Constitution : paras. 4.2 and 5.4. See also Rules of the Home paras. 1, 2 and 28

The researcher also came into contact with the General Manager at meetings of the Board of Trustees, after she had been appointed to the Board as a Trustee. This contact proved fruitful and meaningful but it was to become apparent, with the passage of time, that the researcher, in his capacity as Chairman of the Board of Trustees, was not as acquainted with affairs of the Home, as he might have been.

28.2.2 Appointment as Visitor :

The researcher became increasingly concerned at his lack of knowledge of the workings of the Home and of the ladies who were residing therein. He retired from active practice as an advocate at the end of February 1998. Shortly before his retirement he approached the General Manager of the Home with the view to being appointed as a visitor to the residents of the Home. The General Manager was of the view that there was merit in his request. She gave him an office and at the beginning of March 1998 he commenced the task of visiting the elderly.

It was from this time and in this capacity that he came into regular and close contact with the management. In the course of the visitation programme he came to know and understand the workings of management; what was involved in the day-to-day running of the Home; the administration, the maintenance, the kitchen-staff, the cleaning-staff, the nursing staff, the welfare of the ladies; and the operation of the Frail Care Unit. He came to understand the vast knowledge she had acquired during the twelve years she had fulfilled the task of Honorary Secretary, and the six years, as General Manager.

28.2.3 Acknowledgement of role of manager :

Up to the time of his appointment as visitor, his knowledge of the role and function of the General Manager, was largely confined to his pre-

meeting briefings by the Manager, his sharing with her in problems encountered in her role as Manager, and the part she played in the meetings of the Board of Trustees. Now he was able to observe her in action in her managerial position, he was able to analyse and assess her, and he was able to appreciate her qualities.

In the course of his developing a programme of visitation, he frequently had to turn to her for advice and guidance. She was not only able to deal with problems but she had a profound and caring interest in, and knowledge of, each and every resident. Moreover, she was deeply involved in each facet of the administration and management of the Home. This was not confined to aspects of nursing, or residents' problems, or the kitchen, or the administration, but to the detailed and technical aspects of maintenance.

On an enlightened and intelligent level, she is able to discuss the budget and financial statements with the Accountant, plans with the architect, drainage problems with the plumber, maintenance problems with the handymen, cracked walls with the structural engineer, and medical problems with the doctor and sisters. She can give effective instructions as to how and when walls should be painted, carpets should be laid, and roses should be pruned.

Little is done at a walk; much is done on the run. The Home is competently run because of the efficiency, expertise and experience of the General Manager.

28.2.4 Relationship with the Management :

It is difficult, in developing a programme of visitation, to meet this level of expertise and to match this degree of commitment. One is left with the distinct impression that anything less than excellent is not worth

pursuing. Accordingly, the programme of visitation had to be aimed at excellence; anything less, stood to be rejected. This presented both a problem and a solution.

The problem, first. The requirements and demands of social work fell outside the expertise of the researcher. There were few books, if any, to offer guidance. There were few people, if any, to offer help. But a programme of visitation had to be developed and it had to be good.

The solution, next. The one person who possessed the skills, the knowledge, and the experience was the General Manager, although she made claims to nothing. Accordingly, she became the one to whom to turn; she was the one who in a brief statement or a single comment, could impart a volume of knowledge; and it was in her guidance that direction was found, and the programme kept on course.

Contacts were brief, but regular and continuous. Time was short and talk at a minimum. But there was never a rebuff or a rebuke. Instead, there was encouragement and approval. Excellence has not yet been achieved, but it is in sight.

28.2.5 Interference with Management :

This matter has been considered in another context⁸. It is not intended to repeat what has been said. Emphasis will, however, be placed on five matters. The first arises out of the proximity which exists between the specialised visitor in the operation of the visitation programme, and the General Manager in the day-to-day management of the affairs of the Home. This proximity affords to the specialised visitor the opportunity to observe the general management of the Home by the General Manager at close range. He will obviously form views and opinions concerning the

⁸ See Chapter Twenty-Six : *Interference*

nature and effect of the process of general management. Nothing stops him from commenting favourably upon those aspects of management which make a good impression upon him. The question that arises is what does he do in regard to aspects of management of which he disapproves. This leads to the second of the matters under discussion. However objective the specialised visitor may purport to be in forming his opinion concerning the general management, he must always remember that essentially the opinion is his subjective point of view which may, rightly or wrongly, differ from that of the General Manager. He is entitled to his view, just as the General Manager is entitled to hers, and to act upon it. This leads to the third matter, that is to say, an inclination on the part of the specialised visitor to interfere. He has made an observation, he has formed an opinion, and he is critical of an act of management. It is natural for him to be inclined to interfere. The fourth matter relates to an exercise of judgment on the part of the specialised visitor. However strongly he may feel concerning an act of management, and however inclined he may be to interfere, he must acknowledge and accept that there is no valid basis for him so to do. He must not yield to his inclinations and he must not interfere with management. This leads to the fifth observation. It is important that there is a cordial, co-operative and amicable relationship between the specialised visitor and the General Manager. Interference with management can only lead to ill-feeling, confrontation and conflict. This is not to the advantage and benefit of the specialised visitation programme.

28.2.6 Employment :

The possibility of the employment by the institution of a specialised visitor is not excluded. In the instant case, however, the visitor serves in a voluntary capacity and is not an employee. The specialised visitor does not pursue his vocation for the purpose of receiving compensation in the

form of wages, a salary, commission or other financial benefit. Nor is he bound by the legislative measures and labour regulations which govern the employer-employee relationship. In the result, he enjoys a considerable measure of independence and freedom to pursue the visitation programme without the intervention and control of the management.

Provided he acts within the framework of the Constitution and pursues the visitation programme in accordance with the *ethos* of the Home, and does not, irresponsibly, fly in the face of the management, he will be permitted to follow his calling without the fear of the intervention of the management.

28.2.7 The Visitor in his capacity of Chairman of the Board :

The specialised visitor need not necessarily be Chairman of the Board of Trustees. In the instant case, he serves as Chairman of the Board. This aspect will be dealt with more fully under the next head. At this stage it is raised in connection with the relationship between the visitor and management.

The visitor recognizes and respects the position and authority of the General Manager. At the same time, the General Manager acknowledges and recognizes the position of the visitor as Chairman of the Board. These are two separate and identifiable roles. The role of the visitor is completely separate and distinct from his role as Chairman of the Board, and in acting as Chairman of the Board he executes a role completely separate from that as visitor. The relationship between the visitor and management must be seen in a different light completely from the relationship between the General Manager and the Chairman of the Board.

28.2.8 Assistance to Management :

In the hierarchical structure of the Ladies Christian Home, the specialised visitor does not purport to rank above the General Manager, in his capacity as Chairman of the Board. Nor does he purport to rank below the General Manager, in his capacity as specialised visitor. Rather he seeks to draw alongside the management, and in an auxiliary capacity, to offer whatever assistance is required of him.

First and foremost, he endeavours to assist the management in properly and adequately fulfilling his visitational function and role. It must be borne in mind that in the absence of the specialised visitor, the General Manager must fulfil the task of visitation. Indeed, she does visit many of the residents, but it makes heavy demands on an already over-taxed programme. The specialised visitor assists the management by lightening the load resting upon it.

Secondly, the specialised visitor seeks to assist the management by attending to extra-visitational matters. These matters have been dealt with in some detail⁹. Suffice it here to say that in many respects the specialised visitor fulfils these functions in order to assist the management and to alleviate the burden resting upon the General Manager.

⁹ See Chapter Twenty-Seven : Extra-Visitational Matters

28.3 VISITOR AND BOARD OF TRUSTEES

28.3.1 Appointment :

During or about January 1998 the General Manager acceded to the request of the Chairman of the Board of Trustees to familiarize himself with the working of the Home through a programme of visitation¹⁰. The appointment of himself as a visitor to the residents occurred at the beginning of March 1998.

At a meeting of the Board of Trustees the appointment was confirmed¹¹.

28.3.2 Reports :

At each meeting of the Board of Trustees, the visitor is required to present to the Board a report on his activities. This relates primarily to his function, role and accomplishments as a visitor to the residents. But it also includes any extra-visitational matters which are sufficiently important to take up the time and attention of the Board.

In this context also, it is important to note that the visitor acts in different capacities. Where he reports on visitational matters or extra-visitational activities, he acts in his capacity as specialised visitor, and not in his capacity as Chairman of the Board of Trustees.

¹⁰ See Chapter One : Introduction

¹¹ Meeting of Board of Trustees held on 18th March 1998

28.4 CONCLUSION

The visitor has been investigated in his relationship to the management and the Board of Trustees. While not an employee, it is important that he maintains a cordial relationship with the management, and acts responsibly in relation to the Board. The investigation into the position, role and function of the visitor is still not completed. It continues in a consideration of the multi-faceted role of the visitor.

Chapter 29. THE MULTI-FACETTED ROLE OF THE VISITOR

29.1 INTRODUCTION

The visitor has been described as ‘a matter of singular significance’¹. He has been investigated in a number of contexts.² He will be investigated in a number of further contexts³. But enough has been said to realize that the role played by the specialised visitor is multi-faceted⁴. It is proposed to examine this multi-faceted role under five broad heads.

29.2 VISITATION

The primary task of the specialised visitor is that of visitation. That is the task to which he is called; that is the task to which he is set apart; that is the task which takes up the bulk of his time. Visitation consists, in the first place, of the simple act of calling⁵. Calling on a regular and continuous basis. It is conceded that the contact with the resident is brief; that the exchanges are limited; and that the level of engagement in the life and experience of the resident is not very high. The fact of the matter, however, is that contact is being made, that interest and concern is being demonstrated; and that the resident is not being left isolated, alone or abandoned. It is not conceded that nothing is being achieved by these simple acts of calling. There is no doubt that by reason of the frequency of the operation over an extended period of time a confidence and trust is built up gradually; that a relationship of hope and expectation is developed; and that something new and exciting has been introduced into the way of life of the resident. It is not suggested that simple acts of calling constitute the end result of the visitation programme. Obviously something more is

¹ See Chapter Twenty-Four : Introduction

² See Chapters Twenty-Four to Twenty-Nine

³ See Chapters Thirty to Thirty-Four

⁴ See Chapters Twenty-Five, Twenty-Seven and Twenty-Eight

⁵ See Chapter Twenty-Five : Caller

envisaged and intended. At the same, it must be accepted that the end result cannot be achieved without a certain amount of groundwork being done. Indeed, to try and expedite the programme, or to rush into the private lives of the residents, is something to be avoided. To meet a resident at her point of personal need requires very many acts of calling, for it is in the acts of calling that preparation is made for the more serious engagements in the programme of visitation.

Visitation consists, in the second place, of sojourning, or tarrying for a while⁶. This rarely occurs without there being a relationship of trust and confidence, which invariably takes time and many acts of calling to achieve. But it is a distinct stage, for which the specialised visitor must be ready and prepared. Ready and prepared to spend time; and ready and prepared to share with a resident. He must not be hurried, nor must he overstay his welcome. He must ask questions, but he must not be inquisitive⁷. He must talk, but he must also be ready to listen⁸. The importance of this stage in the programme of visitation cannot be over-emphasised. This is one of the ends to which the programme is directed. Should the specialised visitor fail at this stage of the operation, he may well fail to meet the resident at her point of need, which is the objective to which the visitation programme is directed.

Visitation consists, in the third place, of meeting the resident at her point of need. Where he achieves this end, the specialised visitor enhances the quality of life of the resident, and this is the principal objective of the programme of visitation. This end is not lightly attained. There are many preliminary stages to be reached, and there are many deep and meaningful conversations in which the specialised visitor will have to engage without there being any mention of a particular need. But the engagements in the conversations are themselves an achievement, and certainly add to the quality of life of the resident.

⁶ See Chapter Twenty-Five : Sojourner

⁷ See Chapter Twenty-Five : Inquirer

⁸ See Chapter Twenty-Five : Listener

Institutionalisation offers to a resident many benefits. It also brings with it the prospect of real disadvantages. One such prospect is that the resident finds herself isolated and alone. She can also find herself forsaken by family and friends. The answer to this problem is visitation. Sometimes it is filled by the family who are loyal and dedicated in their devotion to the resident. More often than not, the acts of visitation by the family are sporadic and irregular⁹. In some instances, it occurs very irregularly, if at all. What is required is a specialised pattern of visitation¹⁰. This is the role and function of the specialised visitor, and it is one facet of a multi-faceted role.

29.3 ACCOUNTABLE TO THE BOARD OF TRUSTEES

While the specialised visitor owes a special duty of care to the resident, it is not his only function and role, nor is it the only duty he owes. He also owes a duty of care to the Board of Trustees. This must be seen from three points of view.

The first relates to the constitutional position of the specialised visitor. The Constitution makes no provision for the appointment of a specialised visitor; nor, indeed, for the implementation of a programme of visitation. In fact, it makes no reference to visitation. Accordingly, it must be accepted that the specialised visitor has no constitutional status. But he is bound by the Constitution and cannot operate outside of its provisions. The programme of visitation and the conduct of the specialised visitor must conform to the Mission Statement¹¹. He must foster and encourage the 'primary concern' of the Home¹². He must acknowledge and accept that in all its endeavours, the Home 'is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it

⁹ See Chapter Eighteen : Visitation : The Normal and Regular Pattern.

¹⁰ See Chapter Nineteen : Visitation : The Specialised Pattern

¹¹ The Constitution of the Ladies Christian Home : para. 2

¹² "Its (the Ladies Christian Home) primary concern is for ladies who are elderly, inform and needy; to respect their rights, to accord them dignity, to attend to their welfare, and to ensure their freedom from danger, care or fear." (The Constitution of the Ladies Christian Home para. 2)

cares”¹³. He must subscribe to the Constitutional objects of the Home in undertaking “to provide for the sustenance, health and welfare of the residents of the Home”¹⁴.

The specialised visitor must acknowledge that the “management, government and general conduct of the affairs of the Home shall vest in (the) Board of Trustees who shall exercise all powers necessary and requisite for carrying out the objects of the Home”¹⁵.

The specialised visitor is free to develop and conduct a programme of visitation but in so doing he owes a loyalty and a duty to act in terms of the provisions of the Constitution.

The second relates to the duty that rests upon the specialised visitor to account to the Board of Trustees for his conduct concerning the visitation programme. This must be a true and accurate report. It must reflect both successes and failures. The specialised visitor must refer to difficulties and problems, just as he must share with the Board of Trustees incidents of encouragement and achievement. But he must be cautious. He owes a loyalty to the Board. But he also owes a loyalty to the residents, and he must be careful not to betray confidences.

The third relates to the role of the specialised visitor to conduct himself as a ‘go-between’. He is the one who stands between the resident and the Board. In the event of a resident raising a legitimate concern with the specialised visitor, he will, in the first place, refer it to the General Manager for resolution. In all probability, the matter will be resolved at that level. It is only where it cannot be resolved by reference to the General Manager, that the specialised visitor should feel free to take the matter to the board, if it warrants such attention. This should be on notice to the General Manager, and if at all possible, in a cordial and friendly manner.

¹³ *The Constitution of the Ladies Christian Home* : para. 2

¹⁴ *The Constitution of the Ladies Christian Home* : para. 3.2

¹⁵ *The Constitution of the Ladies Christian Home* : para. 4.1.1

This is included in the role and function of the specialised visitor, and it is another of a multi-faceted role.

29.4 MANAGEMENT

The specialised visitor operates independently of management but not divorced from it. He operates alongside of management, in tandem with it, and as an accessory to it¹⁶.

The management frequently seeks the opinion or advice of the specialised visitor. He considers the problem and offers his objective viewpoint¹⁷. This may, or may not, be accepted but it is offered in good faith and as a party independent of management, but auxiliary to it. From time to time his assistance is requested on matters connected with labour relations. These relate, in the main to disciplinary proceedings, trade-unions and staff matters¹⁸. These are not matters associated with visitation but form part of the multi-faceted role of the specialised visitor.

There are times when special skills are required in connection with letters that have to be written. By and large, this is handled by the administration¹⁹. But there are letters of a particular nature, or official forms to be completed or filled-in. These are usually of a complicated or unusual nature. The management then turns to the specialised visitor and makes use of his abilities in this regard.

Although it does not occur regularly, there are times when the General Manager must absent herself from the Home, such as when she goes on holiday. Someone must be appointed to act in her stead. By the year 2000, this had only happened twice but on both occasions, she turned to the specialised visitor to fill the post. He continues with his programme of visitation but, in addition, fulfills the role of Acting General Manager.

¹⁶ See Chapter Twenty-Seven : Management

¹⁷ See Chapter Twenty-Seven : Objective Viewpoint

¹⁸ See Chapter Twenty-Seven : Disciplinary Proceedings, and Staff Members and Trade Unions

¹⁹ See Chapter Twenty-Seven : Letters

29.5 ADMINISTRATION

For all intents and purposes the administration is the practical arm of the general management. Under the direction and control of the General Manager, the administration attends to the day-to-day running of the Home. It pays the accounts, the salaries, and the pensions. To a very large degree, it also attends to the personal needs and requirements of the residents.

When it encounters difficulties and problems, it turns, as a matter of course, to the General Manager, or the Accountant, if it has financial implications. But there are times when the General Manager is not available, or is under pressure, or for some other reason is unable to attend to the matter. The administration turns to the specialised visitor who is requested to attend to the problem. He gives his assistance, advice or guidance, which the administration may accept or reject as it best sees fit. The specialised visitor fulfills a purposeful role.

It may seem old-fashioned, and even, irrelevant but one of the cherished traditions of the Home is to honour a resident on her birthday. However old-fashioned or irrelevant, it is a practice which carries with it considerable significance. In some instances, it is remembered by the resident but by nobody else. This is unfortunate. A birthday is a special day, even for an elderly person. And everybody likes to be remembered. Certain birthdays, such as the eightieth or ninetieth, is feted by the family or friends, but often, other birthdays do not feature very highly, if at all. The Home tries (within financial limits) to make the day special for the resident, by delivering to her a special message and a little gift.

This is delivered personally by the specialised visitor as an adjunct to the visitation programme. If he cannot do it, or it is appropriate for the General Manager to hand over the gift, it falls to the lot of the General Manager in her administrative role.

The administration attends to the payment of pensions once a month. The Bursar is well-able to fulfil this function. However, it involves dealing with sums of money. She invariably requests the specialised visitor to assist her in this routine monthly task.

29.6 SPIRITUAL ROLE

The name of the institution²⁰, and the provisions of the Constitution²¹ indicate that the Home has strong Christian convictions. Indeed, the Objects make express provision “for the presentation of the gospel of salvation through faith in the Lord Jesus Christ”²². Whether or not these are the reasons is difficult to say but there is a large number of practicing Christians among the residents of the Home. This presents interesting and demanding challenges to the specialised visitor. The Christian emphasis of the Home presents one challenge, while the expectations and requirements of certain of the residents present another. The fact of the matter is that, as far as the Ladies Christian Home is concerned, the specialised visitor must expect to exercise a spiritual role in the discharge of his visitation duties. This is examined in a number of contexts.

The first of these contexts embraces the ability on the part of the specialised visitor to pray with a resident who is thus minded. The expectation on the part of a resident to be led in prayer by the specialised visitor is frequently manifested. It may take the form of an express request, or, more often, it takes the form of an enthusiastic response to an offer by the specialised visitor to lead in prayer.

The second of the contexts relates to a readiness on the part of the specialised visitor to share in private devotions with the resident. A request of this nature usually comes from a resident whose eyesight is poorly. She is often possessed of the devotional material and all that is required of the specialised visitor is to read to the resident the allotted portion, and the appended prayer. It must not, however, be a formality but must be approached with alacrity and enthusiasm.

²⁰ *The Ladies Christian Home*

²¹ *Especially as set forth in the Mission Statement (para. 2) and Objects (para. 3)*

²² *The Constitution of the Ladies Christian Home : para. 3.4*

The third of the contexts relates to a willingness and ability to lead the act of worship which takes place once a week. This only occurs on the occasions when the clergyman appointed to conduct the service fails to attend. Attendance at the service is compulsory. Despite this, most of the residents look forward to participating in worship and are disappointed at the prospect of the service not taking place. It falls to the lot of the specialised visitor to conduct the service when the occasion presents itself. Prudence dictates that the specialised visitor prepare himself for the unexpected.

The fourth of the contexts relates to memorial services. These are held to honour the memory of residents who have died in the Home²³. They are usually conducted by a clergyman. The specialised visitor, however, in the context of the programme of visitation, comes into regular and close contact with the residents. He comes to know them, and they become his friends. It is therefore not unusual that he should be asked to pay tribute to a deceased resident by conducting the memorial service.

29.7 CONCLUSION

The role and function of the specialised visitor is not narrow and confined. While the appellation may suggest a role which is limited to specialised visitation, this is not the case. Certainly, it is the central thrust of his vocation, but it is not the only thrust. His role is multi-faceted, and the ambit of his function extends beyond the single aspect of visitation. He is a man who is required to discharge many tasks, most of which are extremely demanding. As to how he must discharge these tasks, and in particular, the task of visitation requires particular consideration, and it is to this matter that attention is now directed.

²³ See Chapter Twenty-Seven : Memorial Services

Chapter 30. ASPECTS OF COMMUNICATION

30.1 INTRODUCTION

The question that stands to be answered relates to the meaning of the word 'communication' in the context of the programme of specialised visitation. Traced to its Latin origins, it can mean 'to impart or inform' by speaking. It can also mean 'to confer with'. Further, it can mean 'to share something with one'¹. In a more modern context, it can mean 'to transfer information, as facts or emotions, from a source to a receiver' or 'to exchange or share feelings, thoughts, or information'² or 'to exchange ideas or thoughts'³. The word 'communicate' emphasizes that whatever is transferred is then shared, that is to say, becomes the common property of giver and receiver.

Accepting the validity of all these meanings, emphasis is placed, firstly, on 'exchange', that is, to give and receive reciprocally or to interchange. It encompasses, secondly, interaction; a sharing of something more than a mere 'thing' or information, but a sharing of one's very personality, or the opening up of oneself to another. Thirdly, it embraces the concept of participating in the life and experience of somebody else, on a reciprocal basis.

Attention is now directed at the importance of communication in the implementation of the programme of specialised visitation. It is of primary and fundamental importance. Without communication there can be no programme of visitation. Indeed, visitation implies communication as a necessary consequence. However clumsy the visitation programme may be, and however cursory the acts of visitation, the fact remains that communication is an essential element. It cannot be avoided and it cannot be minimized.

¹ Cassell's Latin Dictionary (Cassell and Company, Ltd 1957) see : 'communico'

² MacMillan Contemporary Dictionary (MacMillan Publishing Co., Inc. New York 1979) see : 'communicate'

³ The World Book Dictionary (Field Enterprises Educational Corp. 1975) see : 'communicate'

Moreover, whether or not it forms part of a specialised programme of visitation, there is a need for communication. Without it, the resident becomes withdrawn, isolated and lonely. While it may be dangerous to generalize, it has become manifestly apparent over a period of two years that residents are disinclined to congregate for social engagement. For some inexplicable reason they seem to prefer their own company and resort to the solitude of their own rooms. It is seldom that the visitor knocks on a door and the resident is not present. When absences are encountered, there is invariably a reason therefore such as, for instance, attendance at the Bible study, or the service of worship or the Wednesday morning shopping expedition. As soon as these occurrences are over, however, they repair to their rooms.

It is not that a resident is wont to avoid communication. Indeed, she seems to be appreciative of manifestations of communication, especially when it is demonstrated by the specialised visitor. Seldom is it encountered that a resident is averse to one or other form of communication. Depending upon her mental condition she reacts in a warm and responsive manner. This last observation is important, in that, where a resident is suffering from some form of dementia, this is likely affect the response to the communication, and the duration of the act of visitation.

There is a variety of means of communication by the specialised visitor and it is to these means that attention is now directed.

30.2 SPEECH

Not unexpectedly the most common form of communication is speech, that is to say, the simple act of speaking. It usually takes the form of an expression of certain introductory formalities. And indeed, it may proceed no further, depending upon the

circumstances surrounding the communication. On the other hand, it may deepen into a conversation of varying duration. After utterances of customary greeting, the conversation may proceed in the direction of the resident's health. This may be a formality or a communication of some import, where the health of the resident is a cause for concern. Where it is, it must not be lightly dismissed or forgotten, as this will give rise to a further visit and a further communication, the starting point of which will be the state of health of the resident. The degree of seriousness of the condition will determine the frequency of further visits and the need for concern on the part of the visitor.

The weather may give rise to conversation on two levels. The first is no more than the customary pleasantries. The second is of a graver nature. It may relate to the physical state of the resident. Where this is the case, it stands to be treated in a more serious light. Moreover, if the condition can be remembered against the background of the prevailing weather conditions, it paves the way to intelligent comment at a later stage.

Matters concerning the institution such as the meals, the nursing and cleaning services, the condition of the facilities, and so on, are the subjects of frequent comment and communication. If it is no more than a grumble, the visitor is required to do no more than merely listen. If it is a complaint which has substance, the visitor must engage in the communication and determine the appropriate action that the complaint demands.

There may be communication on aspects of commercial activity, such as shopping or banking, or other personal matters. The response of the visitor must be considered and appropriate. The commercial activity can usually be handled easily, without any great personal involvement. Personal matters are of a different ilk. This is the end to which the visitation programme is directed, and cannot be lightly handled or dismissed. How it is handled depends upon the nature of the problem. It

is of importance if it is giving to the resident cause for concern. The visitor must apply his mind to the problem and take appropriate action, always bearing in mind that the purpose of the exchanges between him and the resident, is to enhance her quality of life.

Conversation is not the only means of the spoken word. The communication can assume other forms. One is prayer. This has been touched on in a number of contexts⁴. Here it is adverted to as a means of communication. There are residents who ask the specialised visitor to pray with them or for them. More frequently, however, the resident awaits the inquiry of the specialised visitor as to whether she would like him to pray with (or for) her. For the visitor who is at home with the practice of prayer, this provides an opportunity for communication between the parties on a very meaningful level.

Associated with the practice of prayer is the reading of the Bible or other devotional material. This occurs with residents who have impaired vision and also provides a means of communication which embraces interchange, interaction and participation on a reciprocal basis⁵.

In the experience of the researcher, there has not been an occasion when communication has manifested itself in the reading of secular material. There has certainly been discussion on the subject of literature as well as the exchange of reading materials. There seems to be no reason why secular reading should not provide an effective means of communication.

The spoken word provides the most usual form of communication. In whatever sphere it may manifest itself, the communication must express itself in meaningful contact; contact which is regular, continuous, and which steers clear of prolonged absence.

⁴ See for instance : *Chapter Twenty-Nine : Spiritual Role*

⁵ See : above : *Introduction*

30.3 ACTIVITIES

Another form of communication, which obviously involves the spoken word, but has another emphasis, is that of activity, that is, the engagement in action or doing something, with, or in the company of the specialised visitor. The most popular of these activities is the participation in the bi-weekly Bingo competition. The specialised visitor participates in an organizing capacity, but the communication occurs in laughter, banter, repartee, and physical and mental engagement.

Other forms of activity manifest themselves in handwork and games. Hitherto the specialised visitor has not played a dominant role in these spheres, but manifestly they present fruitful areas of communication.

For the alert of mind and those who harbour sufficient interest, working on a jigsaw puzzle can be an effective means of communication. Likewise, playing cards or scrabble. The resident and the specialised visitor unite in companionship, engage in conversation, share in laughter, participate in competition, and partake in effective communication.

There are two further activities which can lead to effectual communication. The structure of the Home surrounds a beautiful garden. Walking in the garden with a resident, or pushing her wheelchair on the concrete paths, provides opportunities to talk, share fellowship, and admire the attractiveness of the flowers and trees. Secondly, the management of the Home has permitted a resident to work in a portion of the garden. This, naturally, requires soundness of body and of mind. It is also limited in its application, but it does provide a means of communication.

30.4 WORSHIP

Worship, in its various forms, provides an effective means of communication. The Tuesday morning act of Divine Worship is well attended. The specialised visitor often attends as it is a means of meeting with the residents in a different context, talking to them, and sharing with them in worship. Moreover, if tea is served after the service, it provides a further means of social contact and friendly communication.

Once a month, at the service of Divine Worship, the specialised visitor assists the clergyman in serving the communion. Here, he makes contact with a large number of the residents in a sacred and significant observance. There is personal and intimate contact made with the resident as he serves the bread and wine. Moreover, there are times when he is required to conduct the service. This is a time of particular significance, as he is accorded the opportunity to minister spiritually to his constituency. It is the summation of all that is honourable and worthy in the role of specialised visitor.

Insofar as the specialised visitor has contact with residents of a distinct religious bent, he has an opportunity of particular communication, in that he often makes available to them, meaningful literature. This gives rise to conversation and the exchange of thoughts and ideas⁶.

30.5 SILENCE

Although, seemingly, a contradiction in terms, silence can be a powerful and effective means of communication. It usually relates to the condition of the resident, that is to say, an inability to talk, a disturbed mental state, or deafness. Moreover, it makes strenuous demands upon the specialised visitor in the sense that he is

⁶ See : above : Introduction

required to exercise patience, to sit still for an indeterminate period, to be quiet, and to be deprived of all means of communication, save silence. But for as long as he sits with the resident and engages in quiet contemplation, he communicates with the resident. Some may doubt if anything is achieved but who is prepared to judge?

30.6 TACTILITY

Closely associated with communication by silence, is communication by touch. Again, this means of communication usually relates to the condition of the resident. When no word can be spoken or understood, when the time for engagement in activities or worship is long past, when the resident, to all intents and purposes, has lost contact with reality, all that is left to the specialised visitor is his sense of touch. He draws close to the resident by holding her hand, or gently smoothing her cheek, or rubbing her forearm. She knows he is there, that he has an interest in her, and a concern for her, because she responds to the tactility, so much so that she does not want him to go.

The specialised visitor is never without a means of communication. He speaks when the time is opportune, and when it is not, he acts and does. When the time for action and doing is not appropriate, he shares in worship. When other avenues of communication are denied him, then he resorts to silence and tactility.

30.7 CONCLUSION

The heartbeat of visitation is communication, which expresses itself in many forms. Who will say which means is the most effective? Whichever it is, it rests upon a deep and intimate knowledge of the resident whom he visits. Whence does this information come? It is to this matter that attention is now directed.

Chapter 31. NEED FOR INFORMATION AND THE SOURCES THEREOF

31.1 INTRODUCTION

The specialised visitor needs to be informed. He must know that is going on, not only in the context of the programme of visitation, but in the wider context of the Home. When the lift is not working, the resident wants to know of the specialised visitor why it is not working, when will it be fixed, and how is she to get to the dining room in the meantime. Or when the water is not hot, why is it not hot, when will it be hot again, and how is she meant to wash in the meantime. Or when the handyman is banging, why is he making such a noise, when will he stop, and how is she meant to rest in the meantime.

These are hardly matters which fall within the scope of visitation, but, nonetheless, during visitation, the questions are asked and definitive answers are anticipated. The specialised visitor is expected to have knowledge of these (and countless other) matters. Moreover, ignorance is not lightly excused or condoned. Whether or not they fit comfortably into the scope of visitation is immaterial; they are raised by the residents, and they must be dealt with.

Accordingly, the specialised visitor must be astute and not found to be wanting in any sphere which may be of importance to the resident. The need for information arises in a number of different contexts, and it is to these contexts that attention will now be directed. Thereafter, the sources of information will be analysed and assessed.

31.2 NEED FOR INFORMATION

31.2.1 Constitutional :

If not for the benefit of residents, then for his own benefit, personally and in accordance with the programme of visitation, the specialised visitor stands to be informed on the provisions and requirements of the Constitution. He operates within the framework of these provisions, and, in implementing the visitation programme, he is bound by the spirit and letter of the Constitution.

It behoves him to be thoroughly acquainted with the Mission Statement and the Objects of the Home. Moreover, the programme of visitation must, in all respects, accord with these essential constitutional provisions. In reporting to the Board of Trustees, the specialised visitor must, expressly or by implication, satisfy the Board that he is fully and completely informed of the provisions and requirements of the Constitution and that he is discharging his duties in accordance with them.

31.2.2 Governmental :

For all intents and purposes, the government of the Home resides in the Board of Trustees, the General Manager, the Administration and the Bookkeeper. The specialised visitor stands to be informed on the duties and function of each of these offices. He can determine the nature and scope of the managerial role of the Board of Trustees from a perusal of the Constitution. Moreover, he has direct access to the Board, not so much in his capacity as Trustee or Chairman, but in his capacity as

specialised visitor and can acquaint himself with the workings and operation of the Board. Some residents, too, have a mystical appreciation of the Board of Trustees, and, occasionally, in awesome reverence, approach the subject with the view to determining its workings, or, through the specialised visitor, to try and exert some tentative influence.

The constitutional role and function of the General Manager can, likewise, be ascertained from the Constitution. The practical operation of the office can be ascertained by observation, inquiry, and, to a lesser extent, participation by association. It is important that the specialised visitor be informed on the workings of the general management as this is the arm of government which most closely affects the residents, and materially influences the operation of the Home as a whole. The residents frequently refer to, or inquire into, all manner of managerial affairs, and it behoves the specialised visitor to deal with these inquiries in an authoritative and helpful manner. Nor are these inquiries confined to the residents. They extend also to the employees. It is an informed visitor who is able to attend to such inquiries in an appropriate manner.

The Administration (and the Bookkeeper) operate in close proximity to the specialised visitor and the residents¹. It is important for the visitor to be informed on the operation of the administration and to fully understand the role and functions that are discharged. Moreover, any absences on the part of members of the Administration should be made known to the special visitor as these are among the matters the residents wish to know and about which they frequently ask.

¹ See : *Chapter Twenty-Nine : Administration*

31.2.3 Buildings :

The lay-out of the building is complicated and it takes time and orientation to be fully acquainted with the arrangement of the rooms, lounges, and so on. This is the result of a number of additions that have been made to the buildings over the years. Visitors to the residents, and the more forgetful of the residents themselves frequently get lost. But not only must the specialised visitor be informed of the lay-out of the buildings but he must know the room location of each resident. Furthermore, if a resident moves from one room to another, or is transferred to the Frail Care Unit, the specialised visitor should be informed of the move and the reasons therefore.

There are times when the resident is absent from the Home. One possible reason is a visit to the family. Another is hospitalization. Where this absence is likely to be more than a few days, information should be given to the specialised visitor together with the reasons for the absence.

The specialised visitor should be informed of maintenance or repairs to the buildings which is likely to affect the residents. He should know the background to the maintenance or repairs, the nature thereof, and how long it is likely to last. These are the things that the residents inquire about, especially when it affects their convenience. The specialised visitor must not be caught unawares. His responses must be accurate, authoritative and informative. The residents are quick to observe matters which are out of the ordinary, and they are restless until fully informed.

31.2.4 Personnel :

The personnel with whom the residents are most likely to come into reasonably close contact are the sisters, staff-nurses, kitchen and cleaning staff, and members of the Administration. There are certain matters concerning the employees of the Home which are confidential and need not be disclosed to the residents². In all probability, the specialised visitor will have been fully informed on these matters but in his capacity of Chairman of the Board and not as specialised visitor. Moreover, he will obviously respect the confidentiality of the situation and not make disclosures to the residents.

But in respect of matters which are not confidential and the disclosures of which do not constitute an invasion of privacy, the specialised visitor should be fully informed, so that, if these matters are raised by the residents, they can be accurately informed. The principal point of contact with the residents is the specialised visitor and it is he who should be in a position to impart the facts.

31.2.5 Residents :

The specialised visitor must be kept fully informed on all matters relating to the residents. Those occupying rooms situated in the front of the Home are usually fairly sound of body and of mind. The condition of those in the Frail Care Unit vary from resident to resident but by and large they are located in the Frail Care Unit because they are frail of body or of mind or both.

² For instance : matters concerning discipline or dismissal or the state of health of an employee

Whether sound of body and mind or frail it is important that the specialised visitor be informed of any changes, or accidents, not only for his own edification in relation to the operation of the visitation programme, but to put him in a position to answer the inquiries of interested residents. The situation can give rise to increased or reduced acts of visitation, as the case may demand. The fact of the matter, however, is that, if uninformed, the specialised visitor erroneously visits a resident who should not be visited, or fails to visit a resident who requires immediate and repeated visitation.

Of particular significance in this regard is the case of death of a resident. In a number of cases death is not entirely unexpected but when it does occur, it is a talking point of no small significance. The resident wants to know who died; what was the cause of death; and when will the memorial service be held. The specialised visitor must know the answer to these questions. He must be informed accurately and timeously.

In certain cases, a particular approach is required on the part of the specialised visitor. Whatever the reason, a knock on the door and an entrance into the resident's room would not be a proper and appropriate approach. Indeed, on one case, an elderly lady had an aversion to men and she did not want a man to visit her. It was strongly suggested that no visits to her took place. The reason is unimportant. What is important is that the specialised visitor be informed so that he may adapt the visitation programme to accord with the prevailing circumstances.

31.2.6 Activities :

Various activities take place on different days. On Monday there is a Bible study. On Tuesday, an act of divine worship. On Wednesday,

shopping. On Thursday, exercises, and on Friday, Bingo, games or handwork. The specialised visitor must be acquainted with all the activities; when they take place; and any changes in the usual programme. Moreover, from time to time, special activities are organized and offered by various charity groups. It does not help the visitor not to know exactly what is going on. Furthermore, he must be ready to repeat himself concerning the details of activities, as many of the residents are inclined to forget what has been planned.

31.2.7 Events and occurrences :

In a community which well exceeds one hundred and ten residents, events and occurrences take place. The special visitor must know of these events and occurrences. Moreover, he must be able to offer authoritative and confident comment on each event as inquiries are addressed to him. He must have intimate knowledge of sickness, accidents and deaths, as they occur in the Home. He must be able to offer intelligent comment on each new arrival.

If structural defects require the presence of workmen and machinery, he must know about it. If the lifts are out of order, or there is a noise from persistent hammering, he must be prepared to be bombarded by questions from a constituency who will not lightly be fobbed-off by meaningless and superficial comment. If the specialised visitor cannot enlighten them then who can?

31.2.8 Finances :

This matter relates not to the finances of the residents, as important as that fact may be. The finances referred are the finances of the Home. This is not a recurring inquiry but it does crop-up from time to time. The

residents become insecure and want assurances for the future. They want to know that the Home will not have to close its doors and “put them out on the street”. Obviously, details of the Home’s finances need not be disclosed to them but they do want to know that the future is secure. The specialised visitor must be sufficiently apprised of the finances of the Home, to allay these fears in a confident and convincing manner.

31.2.9 Problems :

The residents encounter personal problems, and problems with members of their family. They feel constrained to discuss these problems with the management or the administration. Save where these disclosures are confidential, the specialised visitor should be informed, so that he can adapt the visitation programme accordingly.

Problems may present themselves in other spheres which are known to the management and administration. Where these touch the residents or affect them in any shape or form, such as problems with the buildings or development programmes, they should discuss it with the specialised visitor who must know and understand the nature of the problems and be able to comment intelligently on them. The specialised visitor loses this standing where he must confess to ignorance, and ascertain facts concerning problems from residents.

31.2.10 Knowledge concerning the Home :

The Ladies Christian Home has a long and distinguished history. The beginnings were humble but they were motivated by a worthy and honourable commitment and conviction³. A century and a quarter has intervened. Enormous developments have taken place but the early

³ See Chapter One : Background

commitment and conviction has not dissipated or diminished. The work, commenced in an unassuming and modest manner, is presently discharged in an enthusiastic and competent fashion. The special visitor needs to be informed of this worthy and excellent past, and it must become, not only part of his own knowledge and experience, but also part of the programme of visitation. Indeed, the programme of visitation must adequately reflect the history of the Home.

31.3 Sources of Information :

31.3.1 General Manager

The General Manager is a woman of vast knowledge and experience. She is thoroughly acquainted with the workings of the Home in all its many facets. Moreover, she has intimate knowledge of all the residents of the Home. She knows their physical and mental states, and can offer helpful comment on any particular aspects of their personalities. In like manner, she has detailed knowledge of all the employees. She operates under heavy pressure but she is never too busy to advise, guide and inform the specialised visitor on any particular resident, or any particular problem that may arise in connection with the programme of visitation.

31.3.2 Administration :

The Administration, in the main, consists of the General Manager, the Bursar and the Bookkeeper. Consideration has been given to the General Manager as a source of information for the specialised visitor. Although the role of the Bookkeeper does, to a certain extent, overlap that of the Bursar, she is more involved in the accounting side of the Administration

and her knowledge concerning the residents is limited. The Bursar, however, is in regular and close contact with most of the residents. She knows them well. Like the General Manager, she not only has a detailed knowledge of the conditions and states of health of many of the residents, but she knows how the Home operates. She has much to offer the specialised visitor by way of information, and she is ever willing to share such information.

31.3.3 Employees :

It is unlikely that the specialised visitor will look to an employee for detailed information concerning a resident. More properly, such an inquiry will be directed at the General Manager or the Bursar. Nonetheless, without causing offence to the Administration, or without interfering in its sphere of operation, the specialised visitor does, from time to time, approach a nursing sister, a nurse or an employee, for information concerning a resident. Within their respective spheres, and on varying levels of expertise, these persons do impart helpful and essential information to the specialised visitor.

31.3.4 Residents :

As a source of helpful information, residents are approached with caution. This is not because they are unwilling to impart the truth but because, in many instances, they are confused and can, in good faith, convey inaccurate information. That having been said, it must be added that there are residents who are willing and able to impart helpful and reliable information to the specialised visitor. It is not suggested that they are speaking 'behind the backs' of other residents or gossiping about them. There are residents who take an interest in what is happening in the

Home, who take time and trouble to meet new arrivals and make them feel at home, and who move about the place and acquaint themselves with what is happening. These residents can be a source of constructive information which can be of assistance to the specialised visitor in the discharge of his task.

31.3.5 Documentation :

There are in existence documents which can provide the specialised visitor with invaluable information. The Constitution is a document which cannot be ignored or overlooked. It informs the specialised visitor, not only of the constitutional workings of the Home, but of its *ethos*, whereby it is governed, and which forms the basis upon which the visitation programme must be moulded and developed. There is a publication which imparts information concerning the early beginnings and the history of the Home⁴.

There are minutes of meetings which cover the full period of the existence of the Home. This provides, not only for interesting reading, but informative reading. The minutes will furnish the specialised visitor with information as to how the Home has developed over an extended period of time, the emphasis that has been manifested from time to time, and the factors that have been regarded as important as the Home has developed.

31.4 CONCLUSION

If the specialised visitor is to be effective in the programme of visitation, he must be informed on a wide-ranging sphere of topics. He must accordingly avail himself of whatever sources are able to provide him with information that will more adequately fit him to discharge his duties. Apart from drawing alongside these sources, he is required to make contact with other specialised functionaries. This matter will be dealt with the next chapter.

⁴ See Chapter One : Background

Chapter 32. OTHER SPECIALISED FUNCTIONARIES

32.1 INTRODUCTION

The term 'functionary' is used to describe a person who serves in a specific function or one who has certain functions or duties to perform. A 'specialised functionary' is one who performs a special or specific function or duty. Observations have been made concerning certain of the 'specialised functionaries' who perform functions and duties at the Ladies Christian Home¹, and indeed, certain of the functions and duties they perform². Observations have also been made concerning the specialised visitor within the context and framework of the duties and functions performed by certain of the specialised functionaries³.

It is not intended to reconsider these observations. It is intended, rather, to examine the principal duty of the specialised functionary, and determine whether such duty can be expanded and extended to cover the principal function and duty of the specialised visitor. If it can, then much of the argument advanced in support of the function, role and appointment of the specialised visitor loses its validity. If the opposite is the case, then it follows, that support is given to the general argument which has been advanced, to the effect that the appointment of a specialised visitor can enhance the quality of life of the elderly. It is accepted that as between all the functionaries, whether specialised or not, there is a common bond, effectively, to communicate with the residents to improve their quality of life. Nonetheless, it is proposed to test the validity of the argument advanced in support of the position of a specialised visitor in the context of the principal duties of the specialised functionaries.

¹ See Chapter Three : *The Institution : its Social Structure*

² See Chapter Two : *The Institution : its Social Function*

³ See Chapters Twenty-seven, Twenty-eight, Twenty-nine and Thirty-one

32.2 SPECIALISED FUNCTIONARIES

32.2.1 Medical Doctor :

In order to determine whether the medical doctor can, in any shape or form, effectively contribute to a visitation programme, a number of factors need to be considered. The first relates to the classification of the resident who requires medical attention. If she is an economic resident, she will see her own medical doctor, usually at his consulting rooms. Occasionally, he will see a resident at the Home, but this occurs only rarely. If she is a sub-economic resident, she will see the District Surgeon who visits the Home twice a week. This is arranged by the Sister who determines whether the resident's condition is such as to warrant seeing the doctor. The resident will be examined by the doctor who will prescribe the appropriate treatment.

The second consideration relates to the approach taken by the doctor. This is essentially professional, medical, and scientific. Its focus is fixed and its scope is limited. The resident approaches the doctor with a particular physical or mental problem and it is to this (or related) problem that the medical doctor applies his mind and attention. It does not encompass social, conversational, or non-medical ends. The consultation is not directed at personal problems or private difficulties. The medical examination relates to a medical condition, no more and no less.

The third consideration relates to the time factor. While it is not suggested that the approach for a medical doctor will be slap-dash or hasty, it is accepted that time is of the essence, and will not be expended on non-essential exchanges, or wiled away on matters unrelated to a health condition.

The fourth consideration, not unconnected to the time factor, relates to the matter of costs. The costs of a medical doctor, for those who have to pay them, do not come cheaply. And even for those economic residents who enjoy the benefit of medical aid, or the sub-economic residents who have the benefit of the services of a District Surgeon, costs still have to be paid in accordance with services rendered and these costs are high.

An assessment of these considerations, taken individually and cumulatively indicate, in clear terms, that the medical doctor, as a specialised functionary does not easily and comfortably fit into the role of the specialised visitor.

32.2.2 Minister of Religion :

Ministers of Religion are no strangers to the Ladies Christian Home. They form part of the Constitutional structure⁴ and fulfil a functional role⁵. In accordance with a monthly roster, a minister of religion conducts a weekly service of Divine worship. On the last Tuesday of each month, the sacrament of Holy Communion is administered. On each Monday morning, a minister of religion conducts a Bible study. He also spends some time in visiting the residents after the Bible study. When a resident dies, a memorial service to honour her life and memory, is usually held. A minister of religion, more often than not, conducts these services.

One would have thought that these ministers, as part of their pastoral duty, and arising out of the close connection they each have with the Home, would have exercised a diligent and committed programme of visitation, at least, to members of their particular denomination who are resident in the Home.

⁴ See : Chapter Three : Appointed Structure (Part-time); Ladies Christian Home Constituion. 4.1.2.2

⁵ See : Chapter Four : Appointed Persons (Part-time)

But they do not. Isolated visits do occur, especially when a resident requests a visit by her minister or the administration of the sacrament of Holy Communion. These visits are few and far between, and to all intents and purposes, can be disregarded. One reason may be that ministers of religion are too busy within their own denominations to find time for the additional duties. Another reason may be that, save in dire and pressing circumstances, ministers of religion spend less time visiting their members than they used to.

In any event, and for whatever reason, and despite the opportunity and a pressing need, ministers of religion, as specialised functionaries are unwilling, or unable, to fit into the role of the specialised visitor.

32.2.3 Therapists :

The occupational therapist and the physiotherapist are two specialised functionaries who fulfil important roles in the Home. The less frequent caller at the Home is the physiotherapist who gives her time and care to special cases requiring her attention and expertise. She comes into close proximity with the resident with whom she is working but with nobody else. Moreover, her visits are infrequent and for a limited duration. What is more, her principal concern is that the resident should benefit from her assistance for as long as a session lasts. When the session is ended, she departs. There is little time for conversation, discussion, or exchanges, other than is needful for the exercises or manipulation she is giving.

The occupational therapist spends more time at the Home, and the activities she imports are more widespread. She comes into close and regular contact with a wider number of residents. She gets to know them well and she befriends them. But she is employed as an occupational therapist; she renders service as an occupational therapist; and she gets paid as an occupational therapist.

As the designation implies, the occupational therapist is concerned with the kind of therapy or treatment that would best help elderly residents who are frail of body or mind, or both. This involves planning programmes that will help the resident better to cope with her condition and may include both occupational therapy and physical therapy.

The occupational therapist is focused in her objective; committed to her calling, and directed at the end of helping the resident cope with the effects of advancing age, by sharing in and carrying out of planned activities. The emphasis is on group participation.

This is something different to visitation. Visitation does not involve participation in group activities; it does not encompass 'curing by doing'. Occupational therapy does not embrace 'one-on-one' oral or silent or tactile engagement, and it does not readily fit into the mould of visitation.

32.2.4 Podiatrist :

The podiatrist, in treating disorders of the resident's feet, fulfils a very important function. However, his visits are not frequent and regular; he has a fixed and defined purpose; and he is available on appointment to a resident who requires his services.

The matter is pursued no further, as it can hardly be argued that a podiatrist will readily fit into a programme of visitation, or will make himself available to improve the life of elderly ladies by visitation and conversation.

32.2.5 Administrators :

For the purposes of the present discussion, the Administrators will be taken to consist of the General Manager, the Bursar and the Trustees. The visitational role of each will be considered.

32.2.5.1 General Manager –

Prior to the appointment of the specialised visitor, the main task of visitation fell to the General Manager. And, indeed, after the appointment of the specialised visitor, the General Manager continued her role and function as visitor to the residents. She keeps in intimate contact with all of the residents, especially those in the Frail Care Unit. But her task as General Manager is very demanding and she feels that the role of visitation requires more time and effort than she can give. Hence her acceding to the request of the specialised visitor to fulfil his principal function and role.

It is suggested that the considerable visitation schedule pursued by the General Manager does not detract from the argument being advanced in support of the recognition of the position of a specialised visitor. Rather it adds to it in the sense, firstly, that there is a need for a programme of visitation; secondly, that the General Manager, by reason of her other commitments, cannot do justice to the visitational requirements of the residents; and thirdly, she is in need of, and relies upon, a person who can initiate and develop a programme of specialised visitation.

32.2.5.2 Bursar –

Although she engages in various acts of visitation, the Bursar does not purport, actively, to pursue a programme of visitation. She does, however, fulfil a very vital role which is related to a visitation programme. Her door is open to the residents, mostly to those who are of a more active disposition. They call upon her regularly, sometimes for something they need, sometimes for assistance with a problem, sometimes just for a chat. But they are always cordially and helpfully received.

She is, however, largely localized in the sense that she must be in her office. Secondly, she is subject to considerable administrative pressures, which leave her with little time for other activities. Thirdly, she is in constant demand by all manner of people for all manner of reasons. Indeed, when she is not in her office, the administration, to a large extent, is thrown into disarray.

The Bursar is of considerable assistance to the specialised visitor but by no stretch of the imagination is it suggested that, in addition to her administrative role, she can embark upon a systematic programme of visitation.

32.2.5.3 Trustees –

The Trustees fulfil an important Constitutional function and role. But this is largely in an advisory and consultative capacity. Apart from personal commitments, there appears to be no good reason why the Trustees should not engage in acts of visitation, or programmes of visitation. But

they do not. Indeed, it was this detachment which exists between the Board and the Home that caused the researcher to become more closely involved in the activities of the Home. It is not suggested that the Trustees do not fulfil an important role in the administration of the Home. Their skills and expertise hold out invaluable benefits and advantages to the Home. But they are not personally involved in the administration of the Home, or in any forms of visitation of the residents.

To complete the picture, it needs to be said that the General Manager, the Accountant and the specialised visitor all serve on the Board of Trustees, and are personally involved in the administration of the Home.

It seems unlikely that in the foreseeable future the Trustees will become engaged in any programmes (or even acts) of visitation.

32.3 SPECIALISED VISITOR

The specialised visitor is set apart, primarily, for the task of visitation. He does fulfil certain extra-visitatorial roles but these are not included in his primary role. A programme of visitation has been initiated; it is being developed; and it is enthusiastically being put into operation. Residents are being regularly and continuously visited; they are being met at their point of need; and, as a result, their quality of life is being improved.

The specialised visitor is not bound by the constraints of time or costs. He visits whomsoever he pleases in accordance with the programme of visitation, and stays with the resident for as long as the occasion demands. There is no need to watch the clock, as no fees or costs are involved. Moreover, the specialised visitor is not

subject to any confining or limiting factors which dictate that he adopts a particular approach or takes a particular line or directs an act of visitation to a particular end. Provided he acts properly, he is free, in any act of visitation, to adopt whatever approach he pleases, to pursue whatever line that wisdom ordains, and to allow any act of visitation to arrive at its logical or desirable conclusion.

Whereas a specialised functionary has a planned and defined agenda, the specialised visitor is free to follow whatever agenda the programme of visitation dictates.

32.4 CONCLUSION

The primary duty of the specialised functionary is to a very large extent rigid and confined. It does not easily admit of expansion or extension. And even where, in principle, it can be expanded or adapted, there are, invariably, reasons to prevent expansion and extension. The investigation suggests that to incorporate a programme of visitation into the primary duties of specialised functionaries, is difficult, if not, impossible.

The primary duty of the specialised visitor is flexible and free. He is at the disposal of the resident to minister to her as the occasion demands. It is suggested that the investigation reveals the recognition of a need for the position of a specialised visitor.

Attention is now directed at a more sombre matter; the visitor and death.

Chapter 33. DEATH

33.1 INTRODUCTION

Death is the end of life. Most people fear death and try to avoid thinking about it. But the fact of the matter is that death is inevitable. All people must die; it is only a matter of time. It is one of the few things in life that can be counted on, that one can be assured will occur. Death sets a limit to one's time in this life. All that a person is and all that a person has done and been is culminated in that person's death.

The specialised visitor operates close to living and to dying. One day he visits the living. The next day the living is dying or dead. It may be said that this is the case of every act of visitation. And this is true. But when the average age is eighty-six, and many are well in their nineties, in any act of visitation, one seems closer to a possible occurrence of death, than in a normal act of visitation.

The specialised visitor cannot realistically avoid death, or, at least, the prospect of death. It is a reality that he must expect to encounter; it is an experience with which he must prepare himself to deal; and, to the best of his ability, he must try and recognize situations and conditions which may eventuate in death.

It is proposed to investigate some of the situations which are likely to present themselves to the specialised visitor in the face of a resident who is dying or has died. This investigation is more than an academic exercise. It is to assist the specialised visitor in his dealing with death.

33.2 THE DEATH POTENTIAL

The Home is not a death 'factory'; nor is it a 'waiting room' which prepares residents for death. It is not a hospital for patients who are terminally-ill; nor is it a hospice for the slowly dying. It is a Home for the living; for those wanting to live; and for those determined to live. It is the specialised role of the specialised visitor to encourage, to strengthen, to comfort and uplift. It is the function of the specialised visitor to engender hope; to help the resident to dream, to imagine, to think, and to plan¹.

But the potential for death is ever-present; it cannot be eliminated. Many friends, contemporaries, and family members have died long before the average age of those living in the Home has been attained. The specialised visitor must not waiver or hesitate in his role and function. He must continue to exercise his specialised role; to encourage, strengthen, comfort and uplift. He must continue to engender hope and a will to live. But he must be aware that death can supervene; suddenly and unexpectedly. And he must be ready and able to adjust his stance and approach. And he must be ready to handle the fact of death.

33.3 THE FACT OF DEATH

Death does not merely present itself as a lingering potential. It occurs. People that you speak to today, die tomorrow. It is an integral part of life. Has the specialised visitor reflected upon death; death in general; and the death of the resident who has died? How much time and energy has he put into examining the feelings, beliefs, hopes, and fears about the end of the life of such a resident? How would he have reacted if he had been told that the resident had a limited time to live? Was she afraid of dying? Was she afraid of death? Could he identify the source of those fears? Had he known that she was dying what would he have talked about? Are there things, emotional and practical, that he would have felt a need to work out with her before she died?²

¹ See : Chapter Twenty-Five : Specialised Role

² See : *Death : The Final Stage of Growth* by Elisabeth Kübler-Ross (Prentice-Hall, Inc., Englewood Cliffs, New Jersey 1975 pp x-xiii)

The specialised visitor must possess the direction and strength necessary to open his eyes and his heart to the realities of death and dying. He will readily accept that death presents a problem. He must be willing and able to accept the challenge and opportunity available to him of dealing with the problem by facing it squarely.

33.4 THE FACT OF RECURRING DEATH

The specialised visitor is required daily to live with the death potential; he must acknowledge and accept the fact of death; but he must go further. Death in an old age home is not isolated or remote. It is recurrent in the sense that a number of elderly ladies can die in a comparatively short period of time, especially in the Frail Care Unit.

The increasing number of deaths among the elderly has, generally speaking, affected attitudes about death. Many people have come to view the elderly as having “lived out their lives”, and as no longer deeply involved in the lives of their families and communities. Such people may experience the death of an elderly person as a minor social and emotional event. This may be difficult for the specialised visitor who, until the time of death, was in regular and close contact with the resident. They spoke, and joked, and laughed. Then death intervened. First one, and then another, and a third.

Humankind may be surrounded by death and destruction as never before, but that is something different. Moreover, human beings have died in numbers too large to comprehend, but that is also different. Here we are dealing with personal contact, personal relationships, personal friendships. This is one of the facts of death with which the specialised visitor will have to come to terms, and which, with experience, he will have to learn to accept.

33.5 DETERIORATION AND REACTION

Death may come suddenly and unexpectedly. The resident may be old but to all intents and purposes, full of life and healthy. A sudden death is always met by shock and surprise, even if it relates to a person of advanced years. It is also met by a measure of heart-searching on the part of the specialised visitor. He reflects upon the times spent together with the resident. Would he have adopted a different approach if he had known she was going to die? Would he have spoken about different things? Would he have talked about death or dying? His real problem is to be sure that he has discharged his duties faithfully and well or, has wasted his time and the time of the resident now dead. Did she, perhaps, want to know what awaits her after this life? It is to this end that the specialised visitor must direct his energies, not necessarily that he has prepared the resident, spiritually, for death, but that, in his times of visitations, he has not wasted his effort, or the resident's time.

Death which is not sudden or unexpected is more problematic. It is characterized, usually, by a period of gradual or rapid deterioration. But whether it be rapid or gradual, it is important that the specialised visitor has made sensitive and meaningful observations concerning the condition of the resident, and is aware of the deterioration. The problem that arises relates to the manner in which the specialised visitor responds or reacts thereto.

One obvious and natural reaction, especially where the deterioration is gradual, is not to yield to the prospect of death, and to encourage the resident to fight for life and an improved state of health. The specialised visitor reacts by drawing alongside the resident as a comforter to offer strength, upliftment, and hope. This hope is not directed to a life after death, but a continuation of the life on earth³.

³ See : *Chapter Twenty-Five : Specialised Role*

But what if the deterioration continues and the prospect of death presents itself as a reality? Must the specialised visitor react by continuing to encourage and plan for a continuation of life on earth? This is a problem of considerable proportions. Accepting that the future is unknown, the options that present themselves are : must the resident be encouraged to live, or must she prepare herself for death?

The answer to the problem lies in the circumstances that prevail in any given situation. In certain circumstances, it will be right and proper to encourage the resident to live, whereas in other circumstances, it will be right and proper to prepare the resident for death. The specialised visitor must be acutely sensitive to the situation that prevails and act accordingly⁴.

33.6 PREPARATION FOR DEATH

There are two primary matters with which the terminal resident must come to terms. One is to decide whether she is going to accept or reject the reality of dying. Denial involves the attitude, “I am going to get better,” in spite of all the indications to the contrary⁵. The second, which presupposes acceptance of the condition, is to decide the resources upon which the resident will draw and the helping agents to which she will turn, to see her through the event of death.

There are two situations which assist a resident to prepare herself to cope with terminal illness. One is a desire for death. This is, invariably, linked to an advanced age; where the resident adopts the attitude that she has lived too long and the time has arrived for her to die. This is by no means a general attitude. A ninety-two year old expressed the view that she was not “old”, nor did she want to hear that word spoken in her presence. The second embraces the concept of ‘tiredness’; where the resident has lived for so many years, that she has grown tired of living. It is not suggested that these are the resident’s only sources of strength to take them through

⁴ See : *Chapter Twenty-Four : Sensitivity*

⁵ See : *Footnote 2 (supra) pp 80-81*

the dying experience. There may be others. But these are distinct helps along the way. It is an indication that the resident has applied her mind to the problem, and possible among other things, has come to terms with death and dying intellectually. This is not without significance. Where a resident has limited sources of help, and the helping agent must resort to a secular approach, an intellectual appreciation of death is not without merit.

There are other sources of help. One is a minister of religion. Another is the family or a member of the family. A third is the specialised visitor. The role of each of these sources of help will be considered.

First, the family. In most cases, the family are reluctant to accept that the resident is about to die. Nonetheless, it is the family who gather at the bed of a dying relative. It is to be doubted, however, that the family make much of a contribution in offering to the resident emotional support as she approaches the end of her life. The investigation is, admittedly, limited but such observations that have been made, indicate that the conversation which takes place is directed towards a social, and not an emotional, end. In all probability, this is due to the reluctance on the part of the family to accept the possibility of the death of the resident.

Second, a religious faith, and more particularly, the religious faith as imparted by a helping agent in the person of a clergyman. The observations that have been made indicate that the assistance given by clergyman to residents facing death is minimal. The clergy seem to be out of touch with members of their respective denominations resident in the Home. Indeed, it is the Home that takes the initiative in enlisting the assistance of a clergyman to minister to a resident who may be approaching death.

Third, the specialised visitor. It is conceded that the experience of the specialised visitor in ministering to the dying is limited. At the same, his frequent and regular visits to residents have, in a number of cases, given to him the opportunity to make observations relating to the deteriorating condition of a resident, to the extent of determining that death is a possibility. In one case under investigation, he enlisted the assistance of the clergyman linked to the Home to minister to the resident.

As will be appreciated, the occurrence of death in the main sphere of operation of the specialised visitor, is limited. With the passage of time, however, these occurrences are likely to increase and if they do, the specialised visitor is suited to offer both secular and spiritual ministry.

33.7 POST-DEATH SITUATION

The post-death situation manifests itself in three principal spheres. The first is to offer comfort and assistance to the relatives of the resident who has died. The assistance referred to relates to the room previously occupied by the resident and the possessions therein contained. This function is discharged almost entirely by the General Manager.

The second relates to the memorial service to honour the life and memory of the deceased. This, in most cases, falls to the lot of a clergyman, though the specialised visitor is called-upon occasionally to assist.

The third relates to the estate of the deceased. This, invariably, falls to the lot of a duly appointed executor and does not involve the Home or its personnel at all.

33.8 CONCLUSION

The ageing process culminates in death and the specialised visitor is called upon, as part of his role and function, to live close to it. The death potential, the fact of death and the recurrence thereof, visiting residents who are close to death, and facing the post-death situation, all come within the ambit of his duties as specialised visitor. He cannot avoid them, and must acquaint himself with them. The visitor has been investigated in the context of the death of the resident. The visitor must be examined in one further context, that is, in relation to cultural and gender matters, and the matter of indigence. It is to these matters that attention is now directed.

Chapter 34. CULTURAL AND GENDER MATTERS; THE MATTER OF INDIGENCE

34.1 INTRODUCTION

The visitor has been investigated in a number of different contexts¹. To give a complete and balanced picture, it is needful to examine the visitor in three further contexts. One relates to cultural matters. The second relates to the matter of gender, and the third, to the matter of indigence. The need for this investigation arises out of the question : to whom does the specialised visitor direct the programme of visitation? The obvious answer to the question is : to the residents of the Home. But who are the residents of the Home? What is the religious background? What is the financial and economic background? Why does the Home make provision for the admission of elderly ladies only?

Once again the answers to the various questions are fairly obvious in the sense that the social and cultural backgrounds vary from person to person. Likewise, the religious and financial backgrounds. As to the matter of gender, this must be considered in an historical perspective and from the point of view of the intentions and motives of the founders, and the prevailing constitutional provisions².

The fact remains that if validity is to be attached to the conclusions to be drawn from the investigation³, the scope of the investigation must be disclosed in order to determine whether there are present factors which limit such scope. The wider the scope of the investigation, the more valid will be the conclusions; the narrower the scope, the less valid the conclusions.

Hence the approach: the visitor will be investigated, first, in a cultural context; then the matter of gender will be considered; and finally, the matter of indigence.

¹ See : Chapter Twenty-Four to Thirty-Three

² See : Chapter One : Background

³ See : Chapter Thirty-Five : Conclusions

34.2 THE CULTURAL CONTEXT

There are two main issues that will be considered under this head. The first relates to the question of race, and the second, to the question of religion.

As one would expect, there are no legal or constitutional restraints applicable to any application for admission to the Home. Historically there were legal restraints but these no longer have any application. Each application is treated on its merits and no preference is given to any racial group. As a matter of fact the majority of the residents belong to the white race group. There are historical reasons for this. One is that a number of the residents were admitted to the Home when legal restraints applied and they have lived in the Home ever since. Another is that the Home is situated in an area inhabited predominantly by white people. A third reason is that the Home is not well-known to people of colour and until it does become better known applications by persons other than the white group are not likely to be many.

None of these reasons have validity any longer. Firstly, the years are passing by and residents are dying. Vacancies occur and applications for admission are made. For as long as there are vacancies, applications for admission will be considered, regardless of any racial group to which the applicant may belong. Secondly, there are no longer any racial restrictions applying to persons taking up residence in the area surrounding the Home. As these people become older and institutionalization becomes a factor, so admissions to the Home will be considered without regard to the race of the applicant. Thirdly, people are moving about more freely, they are becoming more knowledgeable and discerning; and what was hitherto unknown, is rapidly becoming known. In the result, where age and institutionalization present themselves as relevant factors, application for admission to the Home will likewise become a relevant factor.

The fact remains that during the period of investigation, the residents of the Home were predominantly white. What effect does this have on the investigation? It is suggested, none at all. The ageing process occurs in people of all races. The effect of the ageing process is the same, whatever may be the colour of the skin. Institutionalisation may not, in the past, have occurred in black society as often as it has in white society. But this has nothing to do with skin colour. It is essentially a cultural matter and when institutionalization is available to all society, there is no reason why it should be any different in form to a black person as it is to a white person. Moreover, the problems which beset white families in the process of institutionalization will, in like manner, beset black families. These problems relate to a process and not to skin colour. Likewise, the engagement of the family, in the pre-institutionalisation as well as post-institutionalisation position, is likely to be identical because it has nothing to do with skin colour. All that has been said regarding visitation and the specialised visitor has equal application to those of a dark skin as it has to those of a light skin.

It is suggested that the outcome of the investigation, and the conclusions reached, would have been the same had it been undertaken in a home which was occupied predominantly by black residents, and that skin colour can have no material effects on the eventual outcome, of the investigation.

The second main cultural issue relates to the question of religion. It has been observed that the Home is known as the Ladies Christian Home⁴. It has also been observed that the objects of the Home have a distinct religious, spiritual and Christian emphasis⁵. Moreover, from the time of its founding, it was envisaged that the Home would “be run on stated religious principles, namely, Evangelical, Protestant and non-sectarian”⁶. Five of the Trustees appointed to serve on the Board

⁴ See : *Chapter One : Background*

⁵ See : *Chapter Two : The Scope of the Investigation*

⁶ *The Ladies Christian Home Constitution para. 1*

represent five Christian denominations⁷ and one of these Trustees is charged with “the spiritual welfare of the Home whose task it shall be to oversee and co-ordinate the spiritual activities in the Home”⁸. The General Manager is required to be “in sympathy with and in sympathy with and supportive of the general principles upon which the Home is structured”⁹.

Enough has been said clearly to indicate that the Home strenuously supports the Christian faith. The question that arises, once again, is whether this strong support for the Christian religion affects the investigation to the extent that doubt is cast on the validity of the conclusions reached?

The first observation that stands to be made is that a prospective resident is not required to subscribe to a statement of faith as a condition precedent to admission to the Home as a resident. For administrative reasons she is required to state her church affiliation but her failure so to do, does not disqualify her from admission to the Home. She is not required to possess a faith, nor belong to a church denomination. She does not have to agree to a Christian burial or a memorial service. While she is required (mental and physical health permitting) to attend the weekly service of Divine worship, she does not have to partake of the sacrament of Holy Communion. Nor does she have to attend the weekly Bible study.

The second observation relates to the various religious or spiritual states that manifest themselves among the residents. It must be borne in mind that these are manifestations which have been detected by the specialised visitor who does not hold himself out to be a religious mentor or spiritual adviser or pastor to the residents. His is essentially a secular role which may have religious or spiritual overtones. Moreover, they purport to be no more than detections and not accurate deductions from ascertained facts. The first is that there is a fairly large group who are committed to a fundamental, evangelical Christianity. They are frequently observed in fervent and dedicated Bible study and devotions.

⁷ See : Chapter Three : Appointed Structure (Part-time)

⁸ The Ladies Christian Home Constitution para. 4.1.3.1

⁹ See : Chapter Five : Function of the Administration

They clearly fit in the prescribed mould as envisaged and determined by the Constitution. The second is a larger group who may be termed nominal Christian. If asked, they would claim to be Christians or one-time churchgoers or members of a particular denomination. But they lack the ardour or fervour of the first mentioned group. The third is an equally large group who makes no claim to religious beliefs or Christian commitment. They would be offended to be termed heathens but they are not Christians. The fourth is that group who, because of some form of dementia, have lost their rationality. The state of mind of the resident is such that it is not easy to determine what the nature of her religious or spiritual state is. Nor is it easy to have any effect upon her religious or spiritual state.

The third observation relates to the fact that among the residents there are no adherents to non-Christian religions. The probable reason for this state of affairs is that it is unlikely that an adherent to a non-Christian religion (or the family of such a person) would apply for admission to an institution which is clearly and unequivocally Christian in its emphasis.

But whatever the reason, or whatever the religious or spiritual state of a resident may be, the question that arises is what difference does it make to the matter of institutionalization, or the need for visitation, and what effect can it have upon the validity of the conclusions reached herein? The ageing process affects the religious and the non-religious in exactly the same way. The process of institutionalization presents the same problems to the religious as it does to the non-religious (and to their respective families). The religious resident needs to be visited. So does the non-religious resident. The religious resident experiences loneliness, the need to talk to someone, and the burdens of personal problems. So does the non-religious resident. The argument that has been advanced in support of the role of a specialised visitor applies equally to the religious and to the non-religious.

As with the question of race, so with the question of religion, it is suggested that the outcome of the investigation, and the conclusions reached, will be the same, if undertaken in a home which is predominantly religious or a home which is predominantly non-religious, or, for that matter, a home, the residents of which are predominantly non-Christian.

Culture has to do with a way of life. It consists of all the ideas, objects, and ways of doing things within the context of a particular group; and incorporates the arts, beliefs, customs, inventions, language, technology, and traditions of that group. Culture consists of learned ways of acting, feeling, and thinking, rather than biologically determined ways.¹⁰ It has nothing to do with the process of growing old, or the effects of growing old, in the sense that the people of all cultures grow old and the infirm are to be found in all societies, whatever cultural level pertains. It may well have something to do with the process of care meted out to the elderly, and therefore, to the process of institutionalization. This, in itself, is a cultural matter which must be addressed as it does present a problem in South African society.

The first aspect of the problem relates to the racially based policies of the past. There are a number of facets to this aspect of the problem. One is that these racially based policies benefited a minority of the population. In 1993, about 11% of elderly whites were in homes compared to less than 0,5% of blacks¹¹. A second is that admission policies at old age homes tended to be racist and favour the white group.

In other words, the composition of old age homes did not reflect broadly the race composition of South Africa¹². A third is that there is a huge need for frail care accommodation in the black and coloured areas¹³. A fourth is that there are only about 589 old age homes accommodating about 34 000 older persons, when there

¹⁰ See: Prof. Dian Joubert: *Societas: Sosiologiese Begrippe: 1-50* p. 38; *The World Book Encyclopedia (supra)* Vol. 4 p. 942.

¹¹ See : *Financial Mail* April 23, 1999 : *Current Affairs. Retirement Homes*

¹² See : *Welfare Update* Vol. 4. No. 3. December 1998

¹³ See : *Financial Mail*, April 23, 1999 : *Current Affairs. Retirement Homes*

are about 3 million people older than 60 in South Africa. Of the total South African population, 7% of people are older than 60, and it is generally accepted that this percentage will increase in the twenty-first century. In the Eastern Cape, 8,5% of the people are older than 60 but the province has only 61 facilities. In the Northern Cape, 7,6% of the people are older than 60, but the province has only 9 facilities. In the Western Cape, 7,7% of the people are older than 60 and the province has 186 facilities, while Gauteng which has 6,3% of people older than 60, has 249 facilities, which is more than any other province¹⁴.

The second aspect of the problem relates to the new approach that is being adopted by the South African government in regard to the elderly. There are three facets to this approach. Firstly, it recognizes that ageing is a natural part of a person's life. Secondly, it maintains that older people must be allowed to age as part of their families and communities and not isolated in institutions. Thirdly, elderly people should only be admitted to institutions if they are very sickly and in need of specialised care¹⁵. The guiding principle of the policy is that older persons should be enabled to enjoy an active, healthy and independent life as part of family and community as long as possible¹⁶.

The third aspect of the problem relates to the future of institutions and the process of institutionalization. The fact of the matter is that the government can no longer afford generous subsidies to old age homes. It has to use its welfare resources to help the poorest across all race groups, not just whites¹⁷. The effects of this are manifold. One effect is that the government's subsidy to old age homes has reduced considerably. The second effect is that the number of people in white old age homes has fallen from 53 000 to fewer than 30 000. The third effect is that many homes are having to ask residents' relatives to make a cash contribution to their upkeep because the social pension plus the subsidy no longer covers the cost of care. The

¹⁴ See : *Speech by the Minister for Welfare and Population Development delivered on 17 December 1998*

¹⁵ See : *Speech by the Minister for Welfare and Population Development delivered on 17 December 1998*

¹⁶ See : *South Africa's new approach to ageing : Welfare Update, December 1998 Vol 4 No 3*

¹⁷ See : *Financial Mail April 23, 1999 : Current Affairs . Retirement Homes*

fourth effect is that the continued existence of some homes is placed in jeopardy because they are unable to make ends meet¹⁸. Does this mean that the days of old age homes and the process of institutionalization are numbered?

This leads to the fourth aspect of the problem and requires a consideration of a number of factors. The first factor is the acceptance of the reality of the ageing process. For as long as they are able, older people are capable of ageing as part of the family, and the community; they are capable of participating in community life; they are capable of remaining economically active. They are not a burden. They are an asset. But what happens when the ageing process takes its inevitable toll? When the age of 60 has passed. And 65. Then, 70 and 75. What happens when they become frail and forgetful and incontinent? When do they constitute an 'exceptional case of frailty' or 'are very sickly and need specialised care'? Institutionalisation is envisaged in government policy. The question that arises is: when? This gives rise to the second factor.

For as long as they are able, older people fit comfortably into the family, the community, and the economy. Who takes care of them when they are no longer able to look after themselves? When they are no longer an asset but a burden? When they can no longer participate in community life, and economically, they become inactive? A stable economy presupposes the adults in the family engaging in the economy, and social progress presupposes the children being away at school or at institutions of higher learning. Institutions are expensive to maintain and they do deprive older people of the opportunity to participate in community life but they do fulfil an essential function where they are no longer able to look after themselves.

The third factor is the acceptance of the social emergence and economic emancipation of a previously deprived section of society. Social emergence and economic emancipation lead to an attainment of what, previously, was unattainable. Whereas institutionalisation was once the prerogative of the white minority, it now

¹⁸ See : *Financial Mail* April 23, 1999 : *Current Affairs. Retirement Homes*

becomes the right of those who have emerged socially and are emancipated economically. It is not suggested that the role of community-based models of care should be minimized, or its scope, limited. Nor is it suggested that the new policy opens itself to criticism merely because the effect of its implementation is to reduce government's subsidy to old age homes. If community-based models of care are designed to take social services into rural areas, and to the poorer provinces, as also to majority of the population, then it is to be encouraged.

What is being suggested is that with the implementation of the new policy, the old and more expensive policy, ought not to be jettisoned completely as it is likely to fulfil a useful function to the new emerging society.

The fourth factor of the problem relates to the financing of old age homes. One matter cannot be gainsaid : the government can no longer afford to give generous subsidies to old age homes, as a result whereof its contribution has decreased considerably. This has meant that several old age homes are in financial difficulty. What is required is the adoption of a virile economic policy. This embraces, firstly, a sound investment strategy which provides for income as well as capital growth to act as a hedge against inflation. Secondly, it involves the admission of a number of economic residents whose increased financial contribution can subsidize the lesser contribution of the poorer residents. Thirdly, it requires the relatives of residents to make a fixed, regular cash contribution towards the upkeep of the resident. Fourthly, it embodies fundraising on a sophisticated and effective level, such as payments of sums from companies, trusts, institutions and legacies. Fifthly, it involves the admission to the institution of those who are frail and in need of specialised care and who will be subsidised.

Not all institutions can implement these measures. Some are small, independent homes; many are poorly managed and some are in poor areas where relatives cannot afford to augment the resident's contribution, and fundraising opportunities are limited¹⁹. But many can and will survive the financial crisis.

¹⁹ See : *Financial Mail* April 23, 1999. *Current Affairs. Retirement Homes*

One cannot prognosticate with any degree of certainty but it may be suggested reasonably that not all the established old age homes will close their doors because of the new approach of the government. Homes run on an economic basis will, in all probability, survive. As will those who cater for economic as well as sub-economic residents and who have a sound financial policy and backing. Thirdly, those who operate in terms of government policy and admit those who are very sickly and need specialised care, will be subsidized and will probably survive.

The conclusion to which one comes, therefore, is that cultural factors, while not affecting the ageing process can affect the process of institutionalisation. But a further conclusion is that this will not affect the need for visitation, and in particular, the need for specialised visitation. It presents itself, initially at least, as a limiting factor but, in the long run, not a nullifying factor.

34.3 THE MATTER OF GENDER

The matter of gender is pertinent in that the investigation was carried out in a home all the residents of which were ladies. Is this a limiting factor? Viewing the investigation as a whole, do different criteria apply to homes which cater for residents who are men?

Historically, the founders sought to provide a Home for aged and indigent Ladies. Motivationally, a concern was expressed for the sad condition of elderly ladies living in reduced circumstances²⁰.

The prevailing constitutional provisions do not affect the position²¹. But what of the factors which relate to the institutionalization of aged men as opposed to aged women? Is there any difference in the importance of the visitation of aged men as opposed to aged women? And what of specialised visitation? Does it have validity in relation to aged men and aged women?

²⁰ See : Chapter One : Background

²¹ Promotion of Equality and Prevention of Unfair Discrimination Act No 4 of 2000

The ageing process does not distinguish between male and female. Men get old, frail, feeble and sickly, just as women get old, frail, feeble and sickly. Men reach a stage in life when they need specialised care, just as women reach a stage in life when they need specialised care. The institutionalization process, in all its various facets, applies equally to men and to women²². As for the family, with the prospect of institutionalization, they face similar problems, difficulties and distresses with male relatives as they do with female relatives²³. Likewise with visitation, in its normal or regular pattern as well as its specialised pattern, there is no manifest difference between a male resident and a female resident. Both have a need for visitation, the facts and circumstances giving rise to visitation, and the benefits and advantages arising therefrom, apply equally to men and to women²⁴.

In the circumstances, the argument is advanced that the matter of gender does not constitute a limiting factor as far as the investigation as a whole is concerned, and it does not affect the validity of the investigation. Nor does it affect, in any substantial way, the conclusions drawn from the investigation.

34.4 THE MATTER OF INDIGENCE

Historically, the purpose of the founders of the Ladies Christian Home was to provide a Home for 'aged and indigent Ladies'. Motivationally, the Home was for the reception of 'aged, infirm and indigent ladies'. Originally the name of the Home was the 'Christian Home for Aged, Infirm and Indigent Ladies, and for Christian Workers'²⁵. Constitutionally, the primary concern of the Home is for ladies who are 'elderly, infirm and needy'²⁶ and one of the objects of the Home is to provide for 'elderly and needy persons'²⁷.

²² See : Chapters Six to Twelve

²³ See : Chapters Thirteen to Fifteen

²⁴ See : Chapters Sixteen to Twenty-Three

²⁵ See : Chapter One : Background

²⁶ See : Chapter One : Introduction

²⁷ See : Chapter Four : Constitutional Functional

These objectives have not changed²⁸. But severe economic pressures and the ravages of inflation have given rise to certain changes. One change is the admission of a number of economic residents. These are residents who are not indigent and who pay board and lodging in a sum substantially more than that paid by sub-economic or indigent residents²⁹. Moreover, the sum they pay is more than the minimum calculated to maintain a resident in the Home. The object of this change is that these residents, who are in the minority compared to the sub-economic or indigent residents, subsidize those residents who are financially unable to pay the budgeted minimum required to maintain a resident in the Home. It must be emphasized that no distinction is drawn between economic residents and sub-economic or indigent residents. The fact that they pay more does not entitle them to any special privileges, advantages or benefits.

The third category of resident comprises those who are indigent. They are unable to pay the budgeted minimum and do not have family support to make up the shortfall. No change has been made regard to this category. Where the genuineness of the indigence has been established in a proper case for institutionalization, admission will not be refused for lack of finances. Moreover, a resident, who with the passage of time, has become unable to pay the budgeted minimum (and who has no means of making-up the shortfall) will not be turned out of the Home. The Home carries the shortfall in terms of its objects and treats the matter as a 'charity case'.

In determining the relevance of indigence in regard to its effects on the investigation or the validity of the conclusions drawn, two observations stand to be made. The first relates to the composition of the Home. While the economic residents constitute the minority, the fact of the matter is that the membership of the Home does not comprise solely of indigent residents. Some are indigent. Some are not. Indeed, from the point of view of visitation, no distinction is drawn between residents who are indigent and those who are not. The second relates to the matter of indigence in relation to the matter of visitation. It is suggested that it bears no relevance whatsoever.

²⁸ See : Chapter Five : *The Emphasis of the Administration*

²⁹ As at May 2000 there were 25 economic residents in the Home

Indigence relates to the state of a person's poorness. It has no bearing on the ageing process; the process of institutionalisation; or the matter of visitation in the sense that both the poor and the rich grow old, both manifest the effects of the ageing process, both become infirm, both may require institutionalisation, and visitation is of importance to both, when institutionalised. Accordingly, it has no effect on the investigation and does not affect the validity of the conclusions arising out of the investigation.

34.5 CONCLUSION

The visitor has been investigated in the contexts of culture, gender and indigence in order to determine whether they constitute limiting factors on the scope of the investigation and thereby reflect upon the validity of the conclusions drawn from the investigation. In each instance, the suggestion has been advanced that they are not limiting factors, and do not affect the validity of the conclusions drawn.

This concludes the investigation. Certain conclusions will now be drawn and thereafter, recommendations will be made.

SECTION H. FINALITIES

Chapter 35. CONCLUSIONS

35.1 INTRODUCTION

Various facets of the institutionalization of the aged, the importance of visitation, and the role of the specialised visitor have been investigated in a number of different contexts. The primary purpose of the investigation was to determine a means or a variety of means whereby the quality of life of the aged could be improved. But there were associated purposes. Included in these was an investigation into the nature and effect of the ageing process; secondly, to determine the nature and effect of the institutionalization process; thirdly, to examine the nature and effect of a programme of specialised visitation and to determine whether there is a need among the elderly for such a programme; and fourthly, to assess the advantages and benefits, if any, of a programme of specialised visitation to the elderly. One of the ends to which the purposes of the investigation was directed was to arrive at valid conclusions relating to the quality of life of the institutionalised aged¹.

It is to these conclusions that attention is now directed.

35.2 FIRST CONCLUSION : The Ageing Process

In the absence of death, the ageing process cannot be avoided. It touches practically everyone, either directly, in the sense of people, themselves, growing old, or indirectly, in the sense of them being involved in the lives of others who are growing old. In one form or another it is difficult to avoid coming to terms with the nature and effect of the ageing process².

¹ See : Chapter Two : *The Purpose of the Investigation*

² See : Chapter One : *Approach*

As people grow older, their bodies are subject to physiological degeneration. The cells of the body lose their power of repair, and the glands tend to function less efficiently. Digestion becomes disturbed, and the senses of taste, smell, sight and hearing often weaken or begin to fail. In the ageing process, the condition of the blood vessels is the most significant single factor. Hardening of the arteries, the wearing out of the muscular tissues of the blood vessels, and heart failure, are the result of degenerative changes in the tissues. Afflictions among the elderly include arthritis, rheumatism, hardening of the arteries, high blood pressure, and nervous and mental disorders.

The mind of an aged person often becomes feeble and she may be so confused that she requires constant care and attention, and cannot be left alone. As the situation deteriorates, coherent communication with others becomes difficult, even impossible, and helplessness, incontinence, and the loss of brain function may be noted. For old people, whether affected physically or mentally, movement becomes more difficult with age. By the age of eighty, about half the muscle cells have been replaced by other kinds of tissue³.

The nature and effects of the ageing process covers a wide area. They may be physical as in the case of impaired hearing, loss of eyesight, arthritis, osteoporosis, swollen ankles, incontinence, or diseases of the heart and blood vessels⁴; or they may be memory-related problems resulting from a hardening of the arteries and diminished circulation of the blood and Alzheimer's Disease⁵; or they may be personal or emotional problems, resulting in unexplained weeping⁶.

But whatever the nature and effect of the ageing process, it gives rise to the need for care. What is needed, firstly, is a knowledge and understanding of the nature and

³ See : Chapter Eight : *The Nature of the Ageing Process*

⁴ See : Chapter Eight : *Physical*

⁵ See : Chapter Eight : *Memory*

⁶ See : Chapter Eight : *Personal or Emotional*

effects of the ageing process. Secondly, the need is for an analysis and assessment of the person to determine the extent of the nature and effects of the ageing process and whether specialised care is advocated. Thirdly, the need is for the availability of means whereby care can effectively and efficiently be administered. Fourthly, the need is for a commitment to administering a type of care which is directed at the end of enhancing and improving the quality of life of the person suffering the effects of the ageing process.

The question arises as to who is to meet these needs? The first and obvious answer is the family. It is they who are closest to the person and it is they who can best determine the effects that are being brought about by the ageing process. Moreover, it is they who, in some measure, at least, are able to minister to the person and render assistance. At the same time, the older the person gets and the more critical are the effects of the ageing process, the more difficult it becomes for the family to render efficient assistance. Indeed, in many instances, the stage is reached when the family can no longer cope with the situation. Another possibility relates to the various aspects of community-based care. But here, whatever the form the care may take, the point is ultimately reached when the effects of the ageing process are such that the care being administered is insufficient and something more is needed. This introduces the role and function of the institution, concerning which certain conclusions will presently be recorded.

The first conclusion, therefore, stated simply, is that, in the absence of death, the effects of the ageing process cannot be avoided and when these effects reach the stage that specialised care is required, the institution has a role and function to fulfil.

35.3 SECOND CONCLUSION : The Institution

The institution has a role and function to fulfil; a role and function which expresses itself in the efficient administration of care to those who are suffering the effects of the ageing process, and an improvement in their quality of life. In order to achieve this end it must be adequate in a number of spheres. It is to these spheres that attention is now directed.

Firstly, there is the structure of the institution. Structure, here, is used in two senses. One is the physical structure. The other is the social structure. If the institution is to improve the quality of life of the resident, the various aspects of its structure must be attractive, practical and facilitative. This relates, primarily, to the rooms and bathrooms but also to the dining rooms, lounges, meeting places and lifts. Of cardinal importance is the availability of a Frail Care Unit. It is a source of considerable concern as to what happens when the resident's condition deteriorates. The provision of frail care facilities is a matter of great comfort to a resident. A garden may seem incidental and unimportant but it is not. It gives pleasure and peace to residents, and as such, improves their quality of life. Furthermore, the facilities must be well-maintained and kept in good working order.

The social structure of the institution is no less important than the physical structure. It must be adequate. A well-established, closely interrelated and systematically co-ordinated social structure cannot be overemphasized. It provides a sound foundation for an institution which is able to fulfil an efficient and worthwhile social function (a matter to which attention will be given presently). Not the least of this social structure is a governing body, a general manager, a medical and nursing staff, a catering establishment, a domestic cleaning service and a maintenance team⁷. The various aspects which constitute the administration bind the separate parts of the social structure together into a unified and focused whole⁸.

⁷ See : Chapter Three : Constitutional Structure, Appointed Structure (Permanent), Appointed Structure (Outsourced)

⁸ See : Chapter Five : Composition of the Administration, Function of the Administration, The Emphasis of the Administration

A social structure is not an end in itself. Its significance lies in providing an organized association wherein a particular social function can be performed⁹, that is to say, a proper work can be accomplished or a particular purpose achieved. Constitutionally, the work to be accomplished and the purpose to be achieved relates the rights, dignity, welfare, sustenance, health and encouragement of ladies who are elderly, infirm and needy¹⁰. This function is directed at the medical health, physical condition and mental state of residents¹¹. It is also directed at the efficient management of the institution; and it relates to helping and to offering succour and aid to residents¹². The social function of the institution is to a very large extent directed at the individual rather than the constituency of residents¹³; and it meets the resident at her point of immediate need¹⁴. In all aspects of its social function, the institution expresses itself in a gentle, calm and caring attitude, that in 'all its endeavours it is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares'¹⁵.

A, structurally, well-established, and functionally, efficiently-run, institution is a costly enterprise. Two factors must be accepted. One is that the government cannot, any longer, afford to give generous subsidies to old age homes. The other is, that in order to survive, old age homes must adopt a viable economic policy¹⁶. A viable economic policy embraces a number of factors. In the first place, it must incorporate sound accounting practices. At the heart of these practices must be a diligently prepared annual budget in accordance with which the institution must operate. There must be a regular and careful preparation of accounts and the

⁹ See : Chapter Four : Introduction

¹⁰ See : Chapter Four : Constitutional Function

¹¹ See : Chapter Four : Appointed Persons (Full Time)

¹² See : Chapter Five : Introduction

¹³ See : Chapter Four : Residents

¹⁴ See : Chapter Five : Function of the Administration

¹⁵ See : Chapter Six : The Institution

¹⁶ See : Chapter Thirty-four : The Cultural Context : The Matter of Indigence

balancing of books. The spending of money must be frugal and systematically monitored. Stores and supplies must be checked and wastages decried. Provision must be made for adequate reserves and the maintenance of buildings and equipment must be scrupulous. In the control of finances there can be no laxity and attention to detail can never be too precise.

In the second place, it must incorporate a sound investment strategy which makes adequate provision for income and, at the same time, provides for capital growth to act as a hedge against inflation. The aim of the investment strategy must be directed at financial independence.

In the third place, it must incorporate a dynamic and innovative income policy. The institution must be ready and able to accommodate economic residents in order to subsidise poorer residents. Where possible, the financial assistance of the family must be enlisted so as to obviate the need for subsidization. The institution must be equipped to accommodate the very sickly and those in need of specialised care, in order to qualify for government subsidy. Finally, the institution must seek financial assistance in the form of grants, legacies and donations from companies, trusts, institutions and testators¹⁷.

The conclusions reached relate to the institution in its structural, functional and financial contexts. A final conclusion must be drawn. This relates to the future of the institution.

The question that falls to be answered is: what is the future of the institution? Does the policy adopted by the government spell the demise of old age homes?¹⁸ Manifestly, this policy has had an adverse effect on institutions caring for the aged. The subsidies paid to old age homes by the government has been reduced. The

¹⁷ See : *Chapter Thirty-four : The Cultural Context : The Matter of Indigence*

¹⁸ See : *Chapter Thirty-four : The Cultural Context*

number of people in old age homes has fallen considerably because they cannot afford to stay there. Several that have been unable to adapt to this new situation have had to seek assistance elsewhere¹⁹. Moreover, it is government policy not to build more institutions because they are expensive to maintain and they do not enhance the participation of older persons in community life²⁰. Does this mark the end of the road for institutions for the aged?

The answer to the question is three-fold. Firstly, and most obviously, government policy does not readily assist or encourage those who are engaged in the care of the institutionalised aged and especially those who have a concern for the indigent aged. It may well be that some institutions which are small, independent, poorly managed and situated in impecunious areas will not survive in this tough, new, economic environment. Secondly, government policy acknowledges, not unfavourably, that the institution has a role and function to play, especially where these are directed at elderly people who are very sickly and in need of specialised care²¹. This is no more than the recognition of the effects of the ageing process, particularly, where it manifests itself in frailty and infirmity. It is also a recognition that the role of the family and the community in caring for the elderly has its limitations. Thirdly, and quite apart from government policy, there are institutions, which will undoubtedly feel the impact of reduced government subsidies, but nonetheless, are sufficiently sound, structurally and functionally, and operate within the framework of an economic policy which is sufficiently viable to ride the financial storm and survive.

The second conclusion, therefore, is that, while the institution will have to face serious financial inroads, it has a role and function to fulfil, and that, for as long as the effects of the ageing process manifest themselves in frailty, infirmity, and a need for specialised care, there is still a future and a need for institutions for the aged.

¹⁹ See : *Financial Mail*, April 23, 1999. *Current Affairs. Retirement Homes*

²⁰ See : *Speech by the Minister for Welfare and Population Development delivered on 17 December 1998*

²¹ See : *Chapter Thirty-four : The Cultural Context*

35.4 THIRD CONCLUSION : The Institutionalisation Process

Institutionalisation is not hospitalization in the sense of providing medical and nursing care for those who are chronically ill, or even, those who are suffering from some acute health problem. Nor is institutionalization, 'hotelisation', that is, the provision of lodgings and food for a fee, for those who have grown tired of housekeeping and the normal demands of everyday life.

Institutionalisation is a process which is inextricably bound up with the effects of the ageing process. It is invariably linked to a deterioration in the physical or mental state of a person resulting in an inability to cope with an existing situation²².

Institutionalisation follows a natural progression. Its starting point is the state or condition of a person. The second stage is an inability to cope with a prevailing situation. The third stage is the recognition of a need for specialised care. The fourth stage is a transfer from the prevailing situation into the situation of specialised care. The final stage is an adjustment to the institutionalised situation²³. Whether or not the recognition of the starting point is any more difficult than the recognition of any of the other stages is problematical, but it is certainly a stage which is difficult to determine.

Sometimes a person, herself, recognizes the effects of the ageing process but more often than not, it is recognized by the family, or a member of the family. Once recognized, it sets in motion a process which is very rarely easy. The onset of the effects of the ageing process, the observation of an inability to cope with a prevailing situation, and the prospect of the need for specialised care are, in themselves, difficulties of considerable magnitude but no less so than the transfer from an existing situation to a situation of specialised care.

²² See : Chapter Seven : *The Nature of Institutionalisation*

²³ See : Chapter Seven : *The Nature of Institutionalisation*

A pivotal aspect of the institutionalization process is the move by the resident from the erstwhile residential home to the institution. It embraces a change of locality; a change of community; a change of lifestyle; a change of pattern of conduct; a change of authority and control. It embraces standardization and control; the resident becomes contextualised; individuality is recognized but as part of the whole; mobility is limited²⁴. The resident's move from one place to another has ramifications of enormous proportions.

Not unexpectedly, the process of institutionalization has given rise to reaction and adaption²⁵. Three reactions are considered. One is that of acceptance of the institutionalised situation; a genuine, enthusiastic and excited acceptance. Another is that of rejection; total and absolute rejection where the resident, regardless of her physical condition, longs for her pre-institutionalised position. The third is that of adaption or adjustment. It may commence with an attitude of rejection or neutrality but with the passage of time, comes an alteration of mind and attitude and in the result, an acceptance of the institutionalised position. The process of institutionalisation is far-reaching in its nature and effects. What it stands for, what it seeks to do, and what it has to offer need to be understood and appreciated. The resident must not be 'dumped' into an institution, or institutionalised with indecent haste; she must be prompted, urged and coaxed, where her condition is such as to justify institutionalization; she must be informed, properly advised, and, if needs be, counselled²⁶.

Is there a viable alternative to institutionalisation? If one accepts the logical sequence of events leading up to institutionalisation, that is, a deterioration in the physical or mental state of a person as a result of the ageing process, which gives rise to an inability to cope with a prevailing situation and the need for specialised care, then it is difficult to envisage a viable alternative to institutionalisation.

²⁴ See : *Chapter Ten : The Nature of the Process of Institutionalization*

²⁵ See : *Chapter Ten : The Effect of the Process of Institutionalization*

²⁶ See : *Chapter Twelve : The Resident and the Need for Counselling*

The third conclusion, therefore, is that, while institutionalisation may give rise to difficulties when it comes to reaction and adaption to the process, for as long as the ageing process gives rise to an inability to cope with a prevailing situation, and the need for specialised care, there is a need for the process of institutionalisation.

35.5 FOURTH CONCLUSION : The Resident

More and more people are getting old, and more and more old people are getting older²⁷. What is 'old'? 'Old age' cannot be defined exactly because the ageing process differs among individuals. A person of advanced age may have a healthier body and a more active mind than a much younger person. Conversely, a person who may be regarded as relatively young can have a diseased body or an affected mind²⁸. What is important is not age in itself, but the effects of the ageing process, or the condition of the resident; her physical condition, her memory with which is associated her difficulty to recognize her own family and friends, and her personal or emotional state²⁹.

The reasons for the institutionalization of a resident are many and varied but in the end it is the condition of the resident that is cardinal. It is the condition which is reflective of the effects of the ageing process³⁰.

The institutionalisation process can induce a considerable measure of trauma to the resident. In order to appreciate this emotional reaction, it is needful to have regard to the pre-institutionalisation position³¹. This position is characterized, among other things, by what formerly constituted the family home; the family itself as it passed through various stages of development; and the freedom and independence formerly enjoyed by the resident. Changes in circumstances do occur and these changes often

²⁷ See : Chapter Eight : The Nature of the Ageing Process : The World Book Encyclopedia vol 14 p 5586 'Old Age'.

²⁸ See : Chapter Eight : The Nature of the Ageing Process

²⁹ See : Chapter Eight : The Effects of the Ageing Process

³⁰ See : Chapter Eight : Conclusion

³¹ See : Chapter Nine : The Resident : The Pre-institutionalisation Position

point in the direction of institutionalization but the break with the past does not come easily³². Memories and nostalgia predominate. All that is good, wholesome and beneficial is treasured and enjoyed. These factors linger for a long time. Whatever physical weaknesses may present themselves, or whatever degree of forgetfulness may frequent the resident, these are constantly and repeatedly overlooked, and the attachment to the home and environs constantly remains. Often, the family, in introducing or suggesting the subject of institutionalization, are blamed for being cruel, unsympathetic and insensitive³³.

Not for all but for many residents institutionalization means the opposite to independence, freedom and the exercise of a free will. It means incarceration in a room; it means control; it means rules; it means conformity. The resident loses her identity and her personality as she is incorporated into a larger body. Whereas before, it was her wants, desires and needs that stood to be satisfied; now she has to surrender her individuality to the corporate body as a whole.

Some residents respond to this new situation with genuine, enthusiastic and excited acceptance. Others find it unacceptable and reject it, totally and absolutely. Yet others, with the passage of time, adjust; there is an alteration of mind and attitude and rejection is replaced by acceptance³⁴.

The resident's way of thinking, acting, or feeling in relation to institutionalisation varies from resident to resident, and from time to time. A removal from one's home and resettlement in an entirely new environment, is a move of major proportions and mixed emotions on the part of the resident must be expected. Solitude is prevalent, and aggravation manifests itself for a variety of reasons. The element of control is often resented and an attitude or reaction towards the Home, or towards

³² See : Chapter Nine : *Changes in Circumstances*

³³ See : Chapter Ten : *The Nature of the Process of Institutionalisation*

³⁴ See : Chapter Ten : *The Effect of the Process of Institutionalisation*

aspects of the social structure of the Home in the person of the doctor, sister, nurse or domestic staff make themselves felt on numerous occasions³⁵. The process of institutionalisation is far reaching in its nature and effects. It needs to be understood, and if needs be, expounded and unfolded³⁶.

There is a role for counselling in the lives of the aged³⁷, that is to say, a means of helping them to adjust to or deal with personal problems or, perhaps to give advice on the process of institutionalisation³⁸. The need is to offer help, to which is linked the receiving of sympathetic attention from the counsellor. This is particularly so where the resident is harbouring doubts, personal feelings, emotions and problems.

The fourth conclusion, therefore, is that there must be a sound reason for institutionalization, which reason is invariably bound up with the condition of the resident, a condition which is reflective of the effects of the ageing process. Moreover, it must be understood and appreciated that in the process of institutionalization, there is a measure of trauma for the resident, which trauma may manifest itself in a variety of attitudes, some good, some bad, and, in the result, give rise to a need for counselling, into which must be incorporated a helping hand and a kindly sympathetic spirit.

35.6 FIFTH CONCLUSION : The Family

The family cannot divorce themselves from the resident in the process of institutionalisation, nor can they divorce themselves from the process of institutionalization itself. If it is in the best interests of the resident to be institutionalised, then there are a number of bridges to be crossed, and leading the way is the family³⁹.

³⁵ See : Chapter Ten : The Effect of the Process of Institutionalisation

³⁶ See : Chapter Ten : Conclusion

³⁷ See : Chapter Twelve : Introduction

³⁸ See : Chapter Twelve : Meaning of Counselling

³⁹ See : Chapter Thirteen : The Role of the Family during Institutionalisation

It is the family who must bear the brunt of the resident's reaction to the prospect of being admitted to an old age home, especially where she manifests a stubborn and obstinate attitude. It is the family who, usually, select the Home which is to accommodate the resident. It is the family who must convince the resident that to take up residence in the Home, is not only the right thing to do, but is, also, in her best interests. It is the family who must attend to the matters surrounding the erstwhile family home and appurtenances. And it is the family who must attend to the transfer of the resident from the former family home to the Home⁴⁰.

The role of the family does not terminate with the institutionalization of the resident. She needs support and she needs people. It is the family upon whom the resident relies for assistance. They must visit her regularly and, like her, become part of the institution. They need to take her out; they need to let her 'sleep over'; and they need to continue to regard her as an important member of the family⁴¹.

The family plays a pivotal role at all stages of the institutionalization process. It is encouraged to greater and more intimate participation. Not the least of this participation relates to the physical, mental and emotional needs of the resident⁴². The family must share in the life and experience of the resident to the ultimate enhancement of the quality of life of the resident⁴³.

The role that can be played by the family in meeting the physical needs of the resident is an auxiliary or passive role whereby the family draw alongside the nursing and medical staff and fulfil a function which favours the general well-being of the resident⁴⁴. What role can the family playing meeting the mental needs of the

⁴⁰ See : Chapter Thirteen : The Role of the Family during Institutionalisation

⁴¹ See : Chapter Thirteen : The Role of the Family after Institutionalisation

⁴² See : Chapter Thirteen : Conclusion

⁴³ See : Chapter Fourteen : The Family

⁴⁴ See : Chapter Fourteen : The Physical Needs

resident? Whatever the mental frailty may be, the family must not avoid them, or pretend they do not exist, or believe that there will be no further consequences. What is required is time, and understanding, and patience⁴⁵.

Stress, and depression, the lack of a forward look or a measure of foresight, a feeling of hopelessness and aimlessness, tiredness, a desire to die or a fear of dying, worry and anxiety are all emotions harboured by the aged. What role can the family play in meeting the emotional needs? Regular visitation, a genuine rapport, the ability to talk, avoidance of confrontation, and sympathetic attention⁴⁶, are all means available to the family of meeting a resident at the point of her emotional need.

The family may also embark upon the provision of informal counselling⁴⁷. Why must family counselling be informal? The reason advanced is that the probabilities favour the proposition that the members of the family possess little or no skills in the art of counselling. Indeed, the suggestion which is advanced in support of informal counselling by the family is no more than that a stage be set which provides for calm and gentle discussion, rather than confrontation and anger. This embraces sympathetic understanding, calm discussion, encouragement, avoidance of sensitive issues, deference to the wishes of the resident, and the enlistment of qualified assistance where matters are raised which are beyond the expertise of the family⁴⁸.

Not the least of the roles required to be played by the family is that of visitation. This must be regular and constant and the family must demonstrate a continuing interest and concern. The resident, if her physical and mental condition permits,

⁴⁵ See : Chapter Fourteen : The Mental Needs

⁴⁶ See : Chapter Fourteen : Emotional Needs

⁴⁷ See : Chapter Thirteen : Conclusion

⁴⁸ See : Chapter Fourteen : Informal Counselling

must be taken out from time to time. She must feel part of the family and not isolated from them. On special occasions she should be invited to sleep over at a family member's home and she should always be made to feel that she is an important member of the family⁴⁹.

The fifth conclusion, therefore, is that the family has an important role to play in the institutionalization of the resident, which role commences at the pre-institutionalization stage and continues throughout the period of institutionalization. It embraces the physical, mental and emotional needs of the resident and manifests itself in informal counselling and visitation.

35.7 SIXTH CONCLUSION: The Visitation Programme

The institutionalised resident stands to be nurtured, encouraged and comforted. This is the point where visitation is most sorely needed, where it is put to the test, and where its contribution to the enhancement of the quality of life of the resident is established. Visitation is not a coincidental, haphazard and aimless occurrence. It is an exercise, an operation and a practice. It involves preparation and conscious effort⁵⁰. The motivating factor of visitation is a caring concern for the resident and it manifests itself in commitment, contact and communication.⁵¹ The primary purpose of visitation must be to envelop the resident with love and continually to hold her in the embrace of the family.⁵²

However careful is the process of incorporation of the resident into the body of the Home, entrenchment and isolation present themselves as very real problems.⁵³ With entrenchment and isolation, comes the need for visitation.⁵⁴ Visitation does occur.

⁴⁹ See : Chapter Thirteen : *The Role of the Family after Institutionalisation*

⁵⁰ See : Chapter Sixteen : *Introduction; and The Meaning of Visitation*

⁵¹ See : Chapter Sixteen : *The Meaning of Visitation*

⁵² See : Chapter Sixteen : *The Purpose of Visitation*

⁵³ See : Chapter Seventeen : *Entrenchment and Isolation*

⁵⁴ See : Chapter Seventeen : *Conclusion*

Visits to residents by members of the family and friends do take place from time to time. Generally speaking, it manifests itself in what may be described as a normal or regular pattern of visitation.⁵⁵

The characteristics of the normal or regular pattern of visitation are, firstly, that in many instances, visitation does not take place at all, or if it does, it is very occasional and very irregular. Secondly, visits during weekdays do occur but their impact is so minimal that it can be disregarded. Thirdly, visits over the week-end are more popular than visits during the week. These apply to a relatively small group of visitors who are fixed and regular in their week-end visits. In rare instances, family members take the resident out, that is, away from the Home, either for a day-visit, or an overnight-visit, a week-end visit, or for a longer period of time. The normal or regular pattern of visitation is far from satisfactory and distinctly disturbing when regard is had to the resident's need for visitation.⁵⁶

There are manifest deficiencies in the normal or regular pattern of visitation. These deficiencies relate to the occurrences of visitation and the participants in acts of visitation.⁵⁷ Getting residents to share in visitation actively and constructively is difficult because little or no time is given to the manner in which the visit is conducted.⁵⁸ The object of the act of visitation and the control thereof need to be analysed and assessed and sufficient time must be given to the visit to make it effective.⁵⁹ Crisis in visitation is not a rare occurrence. Confrontation, arguments and angry exchanges, regrettably, do happen, with unfortunate results.⁶⁰

⁵⁵ See : Chapter Eighteen : Introduction

⁵⁶ See : Chapter Eighteen : Pattern of Visitation

⁵⁷ See : Chapter Eighteen : Occurrences in Visitation and Participants in Visitation

⁵⁸ See : Chapter Eighteen : Sharing in Visitation and Format of Visitation

⁵⁹ See : Chapter Eighteen : Duration of Visitation; Object of Visitation and Control of Visitation

⁶⁰ See : Chapter Eighteen : Crisis in Visitation

Certain facts are incontrovertible. The resident is old; in some cases, she is unwell. She is alive but the length of her days is uncertain. In certain cases, she has the power to reason but this may disappear. Some day she will die. Visitation, then, is no longer possible. She may have something to say, she may wish to communicate, she may harbour a problem, she may be disturbed emotionally and wish to speak to someone. To whom must she speak, and who will speak to her?⁶¹

In a number of respects the normal or regular pattern fails in its objective to improve the quality of life of the resident. The answer to the problem lies in an alternative pattern of visitation, one which overcomes the deficiencies of the normal or regular pattern of visitation, and one which is more conducive to an improved and enhanced quality of life for the institutionalised aged.⁶²

The sixth conclusion, therefore, is that the prevalent mode of visitation manifests itself in the normal or regular pattern of visitation, which is deficient in a number of respects and stands to be improved by the implementation of another pattern of visitation which is more conducive to an improved and enhanced quality of life for the institutionalised aged.

35.8 SEVENTH CONCLUSION : The Specialised Visitation Programme

There is an alternative to the normal or regular pattern of visitation, the result whereof is an improved and enhanced quality of life of the institutionalised aged. That alternative lies in 'specialised visitation' which is something different from ordinary, normal, social visitation. It is a form of visitation which is more intense, more concentrated and more regular. Moreover, it is directed at an improved quality of life of the aged and holds out benefits and advantages for them.⁶³

⁶¹ See : Chapter Eighteen : Regularity in Visitation

⁶² See : Chapter Eighteen : Conclusion

⁶³ See : Chapter Nineteen : Introduction

Specialised visitation is not visitation in a general sense. It is more than ordinary; it is unusual and exceptional. It is founded upon a special relationship arising out of mutual trust and confidence shared between the resident and the specialised visitor. There is no duty or obligation on the specialised visitor to visit a resident. The desire to visit a resident arises out of a caring concern for that resident and an interest in her health and welfare.⁶⁴

Regularity of visitation is not governed by convenience or inconvenience; it is governed by the condition and circumstances of the resident. Where the resident is ill or ailing, or where she is in need of succour and support, the specialised visitor is available for visitation. Each and every visit is carefully planned and the circumstances relating to every resident is watchfully considered. The motivating factors are a caring concern for the welfare of the resident and a desire to see her quality of life improved.⁶⁵

Specialised visitation holds out numerous benefits and advantages to residents. There is continuity, regularity and frequency of visitation; there is personal contact, a caring concern, and a genuine interest demonstrated; supportive care is given to residents; and security is guaranteed so that residents feel free from danger, worry, care and fear.⁶⁶

The facts and circumstances giving rise to a programme of specialised visitation are manifold. The need to be supported in her new environment; the need to be supported in her advanced age, her state of infirmity, her needs and ill-health; the need to combat feelings of adversity, apathy and lack of vision; the need to alleviate her fear and to encourage her so that there is an increase in hope and confidence.⁶⁷

⁶⁴ See : Chapter Nineteen : The 'Special' Nature of Specialised Visitation

⁶⁵ See : Chapter Nineteen : The 'Special' Nature of Specialised Visitation

⁶⁶ See : Chapter Twenty : Visitation : The Benefits and Advantages

⁶⁷ See : Chapter Twenty-One : Visitation : The Facts and Circumstances giving rise thereto

The reaction of the residents to the programme of specialised visitation and their reception of the programme is determined over a period which exceeds two years. At first, the programme was received with suspicion and reserve, even rejection. But the programme was pursued with continuity and regularity, and a manifestation of a genuine concern for the condition of the resident and a real interest in her affairs. This led to an attitude of relaxation and the acceptance of the specialised visitor. Gradually conversation developed and this led to meaningful communication. This in turn, gave rise to the building up of confidences, and the expressed desire for repeated contact. It also gave rise to discussion, exchange of ideas and the expression of personal problems.

It is not suggested that every reaction to the visitation programme is positive and pleasing.⁶⁸ There are adverse reactions but these are minimal and to all intents and purposes can be disregarded. In the main, the specialised visitation is enthusiastically and well-received.⁶⁹

The seventh conclusion, therefore, is that the specialised visitation programme presents a viable alternative to the normal or regular pattern of visitation and that the results of such a programme redound to an improved and enhanced quality of life for the institutionalised aged.

35.9 EIGHTH CONCLUSION : The Specialised Visitor

The role and function of the specialised visitor arises out of three primary characteristics. One is that they find their origins in a calling or vocation. It is not motivated by employment opportunity or economic advancement or professional status. The starting point is an inner conviction, an infinite calling, an earnest

⁶⁸ See : Chapter Twenty-Three : Reaction and Receptivity

⁶⁹ See : Chapter Twenty-Three : Conclusion

urging.⁷⁰ It is a ministry and not an occupation. The second characteristic is that the specialised visitor is not an employee in the ordinary sense of the word. He is specifically set apart for a particular and defined function, to which all other functions are subsidiary and insignificant, namely, that of visitation. This is the end towards which his time, skills and talents are directed to the exclusion of all other aims and objectives.⁷¹ The third characteristic is that his actions, deeds and conduct are distinguished by regularity and continuity. His is not a 'hit-and-miss' operation, his performance is not sporadic or infrequent; it is characterized by constancy and steadfastness.⁷²

It is these qualities that enable the specialised visitor to be, at one time, a caller, making short visits,⁷³ and, at another time, a sojourner, whereby he tarries, abides and remains for longer periods of time.⁷⁴ He is fortified and strengthened at one or other time to be an inquirer, listener, informer and advisor,⁷⁵ and at other times to be an encourager, strengthener, comforter and uplifter.⁷⁶ It is these characteristics which enable the specialised visitor to offer hope to the hopeless, peace to the disturbed, and faith to those in doubt.⁷⁷

The ambit of role and function of the specialised visitor is very wide⁷⁸ and very demanding. Accordingly, the question that had to be considered was: what are the requirements, characteristics and qualities of the person who must fulfil this role and function.⁷⁹ Indeed, the question went so far as to determine whether the

⁷⁰ See : Chapter Twenty-Five : Specialised Role : Calling

⁷¹ See : Chapter Twenty-Five : Introduction

⁷² See : Footnote 71

⁷³ See : Chapter Twenty-Five : Caller

⁷⁴ See : Chapter Twenty-Five : Sojourner

⁷⁵ See : Chapter Twenty-Five : Inquirer, Listener, Informer, Advisor

⁷⁶ See : Chapter Twenty-Five : Encourager, Strengthener, Comforter, Uplifter

⁷⁷ See : Chapter Twenty-Five : Hope, Peace, Faith

⁷⁸ See : Chapter Twenty-Five :

⁷⁹ See : Chapter Twenty-Four :

requirements of a specialised visitor went beyond the attainment of a prospective applicant.⁸⁰ Certain requirements were obvious; he had to be socially minded, show a concern for the elderly, and be able to identify with the aged.⁸¹ At the same time, he had to be humble, sensitive, patient, sympathetic, motivated, perceptive, conscientious, intelligent, spontaneous and consistent.⁸² Are these requirements not sufficient to dampen the ardour of a possible visitor?⁸³ But the possible requirements go further.

It is a distinct advantage to the specialised visitor if he is an educated person of standing who has a strong personality and a fair degree of the varying experiences of life. He must be independent; independent of mind, and, preferably, financially independent. He must be systematic and organized, decisive and analytic. He must act with authority, combine firmness with flexibility, and be able to co-operate with others. He must possess a spiritual sensitivity.⁸⁴

The role and function of the specialised visitor are important. So are the requirements, characteristics and qualities of a person who aspires to the position of a specialised visitor. But as important as these matters may be, there is an equally (if not more) important concern, and that relates to communication. A specialised visitor must be able to communicate with the elderly.⁸⁵ An ability to engage in meaningful conversation is an essential aspect of specialised visitation.⁸⁶ But the specialised visitor must also be ready and able to communicate through the medium of activities.⁸⁷ Worship may not readily be considered to be a means of

⁸⁰ See : Chapter Twenty-Four : Introduction

⁸¹ See : Chapter Twenty-Four : Socially Minded, Concern for the Aged, Identification with the Aged

⁸² See : Chapter Twenty-Four : Humility, Sensitivity, Patience, Sympathy, Motivation, Perception, Conscientiousness, Intelligence, Spontaneity, Consistency

⁸³ See : Chapter Twenty-Four : Introduction

⁸⁴ See : Chapter Twenty-Four : Requirements, Characteristics and Qualities

⁸⁵ See : Chapter Thirty : Introduction

⁸⁶ See : Chapter Thirty : Speech

⁸⁷ See : Chapter Thirty : Activities

communication but it can be, on a very deep and meaningful basis, and unless the specialised visitor can adequately cope with this mode of communication, he may be at a distinct disadvantage.⁸⁸ The scope of communication goes wider and the specialised visitor must be able to engage in other forms of communication, such as silence⁸⁹ and tactility.⁹⁰ The heartbeat of visitation is communication, and the specialised visitor must be adept at all manner and means whereby he can communicate with the aged.⁹¹

The specialised visitor is set apart for the task of visitation. He visits residents regularly and continuously and meets them at their point of need. In the result, their quality of life is being enhanced and improved.⁹²

The eighth conclusion, therefore, is that the specialised visitor has a definite role and function to play in the life and well-being of the elderly. He is a man of exceptional character and personality, he is able to communicate with the elderly, to meet them at their point of need, and so improve their quality of life.

35.10 NINTH CONCLUSION : Finance

Finance is the lifeblood of any institution. It is of particular significance to institutions the concern of which is the indigent in that the process of institutionalisation of indigent elderly people will be at risk if the finances of the particular institution are precarious. Finance determines the nature and condition of its physical structure; it determines the scope and efficiency of the service provided by the institution; and it determines the character and standing of the institution. The source of the finances of an economic home is the affluence of its residents and is regulated by increasing the contribution paid by each resident. The source of the

⁸⁸ See : *Chapter Thirty : Worship*

⁸⁹ See : *Chapter Thirty : Silence*

⁹⁰ See : *Chapter Thirty : Tactility*

⁹¹ See : *Chapter Thirty : Conclusion*

⁹² See : *Thirty-Two ; Specialised Visitor*

finances of a sub-economic home is (potentially, at least) threefold. The first is any finances that the resident is able to pay. The second is the state pension received (and paid over) by the resident. The third is the subsidy paid in respect of each sub-economic resident by the government. It is to these aspects that attention is now directed.

The first and most important aspect to be considered is the subsidy paid by the State. Here two important principles apply. The first is that the higher the income of the resident, the lower the subsidy. The second is that the payment of the subsidy is dependent upon two factors. One relates to the monthly income of the resident, in respect of which there are eight categories ranging from under R600 to over R1301. The other relates to the category, of which there are three, into which the resident falls, ranging from the healthiest to the feeblest; the poorest and the feeblest receives the largest subsidy, while the healthiest resident with an income over R701 receives nothing.

The second aspect to be considered is the pension received by the resident. This amounts to R540 and falls within the monthly income of the resident.

The third aspect to be considered is the total sum received by the resident. If this exceeds R1301, the resident receives no subsidy even if she falls within the category of the most feeble.

Since July 1997 the State has altered the amount of the subsidy paid to residents. In certain instances it has increased, in other instances it has decreased. This in itself is not significant. What is significant is the role played by inflation. Whereas in 1998 the cost of maintaining a resident was approximately R1800 per month, in 2000, this cost rose to R2400 per month. This effectively reduced considerably the subsidies paid by the State in respect of residents and had a devastating effect on sub-economic institutions. The likelihood of material increases in subsidies is remote, even to the extent of meeting, in part, the effects of inflation. What is more likely is an effective reduction in the subsidies paid to residents by the State.

The effect of this is that the institution will have to make itself less reliant upon State finances. This means that it must seek other means of financing itself. It has been suggested, firstly, that within the prevailing financial context, the institution admits residents who are indigent and in need of specialised care. In so doing, it will be operating within the scope of government policy and will receive maximum subsidisation. Secondly, the institution must look to the family of the resident to make good the shortfall in the financial needs of the institution to maintain the resident. Thirdly, the institution must adopt a sound investment strategy to provide for income as well as capital growth to act as a hedge against inflation. The fourth suggestion relates to the admission of economic residents which, in accordance with government policy, is permissible to the extent of 40% of the total number of residents. Economic residents pay a greater monthly contribution and thus subsidize sub-economic residents.⁹³

Of singular significance is the adoption of a sound and realistically based budget and keeping the operation of the institution within the framework of the budget.

The ninth conclusion, therefore, is that the institution cannot operate outside the framework of a sound and feasible financial policy. It must sensibly and realistically adopt a financial policy which is attainable and must always be directed at ensuring that the residents have peace of mind and do not entertain the prospect of having to find other accommodation.

35.11 TENTH CONCLUSION : Limitations

The scope of the investigation has been examined in the light of possible limiting factors which could effect the conclusions which are sought to be drawn from the investigation.⁹⁴ The first was the cultural context with particular reference to race and religion. As far as race was concerned it was contended that the ageing process

⁹³ See : Chapter Thirty-Four: The Cultural Context

⁹⁴ See : Chapter Thirty-Four : Introduction

occurs in people of all races and that the effect of the ageing process is the same whatever may be the colour of the skin. Moreover, it was contended that as institutionalization became available to all society, so institutions would become the refuge of the blacks as it had become the refuge of the whites in the past.⁹⁵

As far as religion was concerned it was contended that the ageing process affects the religious and the non-religious in exactly the same way. Similarly, the process of institutionalization presents the same problems to the religious as it does to the non-religious. Accordingly, the suggestion was made that the outcome of the investigation, would be the same, if undertaken in a home which is predominantly religious or a home which is predominantly non-religious.⁹⁶

Culture has nothing to do with the process of growing old, or the effects of growing old. It may have something to do with the process of care meted out to the elderly, and therefore, to the process of institutionalization. But this will not affect the need for visitation, and in particular, the need for specialised visitation. It may be considered to be a limiting factor of minor proportions but certainly not a nullifying factor.⁹⁷

The ageing process does not distinguish between male and female. Men get old, frail, feeble and sickly, just as women get old, frail, feeble and sickly. Men reach a stage in life when they need specialised care, just as women reach a stage in life when they need specialised care. The institutionalization process applies equally to men and women. The conclusion is reached that gender does not constitute a limiting factor which affects, in any way, the validity of the investigation or the conclusions drawn from the investigation.⁹⁸

⁹⁵ See : Chapter Thirty-Four : The Cultural Context

⁹⁶ See : Chapter Thirty-Four : The Cultural Context

⁹⁷ See : Chapter Thirty-Four : The Cultural Context

⁹⁸ See : Chapter Thirty-Four : The Matter of Gender

The residents in the Home comprise economic residents (who constitute the minority), sub-economic residents, and indigent residents (who constitute the majority). Indigence relates to the state of a person's poorness. It has no bearing on the ageing process, the process of institutionalization, or the matter of visitation. It is not a limiting factor; it has no effect on the investigation, nor does it affect the validity of the conclusions arising out of the investigation.⁹⁹

The tenth conclusion, therefore, is that there are no matters which constitute limiting factors which materially affect the scope of the investigation or reflect adversely upon the validity of the conclusions drawn from the investigation.¹⁰⁰

35.12 CONCLUSION

The Institutionalisation of the Aged, the Importance of Visitation, and the Role of the Specialised Visitor have been investigated in a wide variety of contexts. Conclusions have been drawn and these conclusions have been set out in detail. All that remains to conclude the study is to set out such recommendations as can reasonably be made. It is to this matter that attention is now directed.

⁹⁹ See : *Chapter Thirty-Four : The Matter of Indigence*

¹⁰⁰ See : *Chapter Thirty-Four : Conclusion*

Chapter 36. RECOMMENDATIONS

36.1 INTRODUCTION

The investigation has been completed. Conclusions have been drawn. What remains is the advancement of certain recommendations. It is proposed to make recommendations under three main headings :-

- The Institutionalisation of the Aged
- The Importance of Visitation
- The Role of the Specialised Visitor

These three headings, cumulatively, constitute the subject matter under investigation. Primary recommendations will be made under each head. But these will not constitute the only recommendations. Under each head, also, certain subsidiary recommendations will be made. These are no less important and must be considered significant and worthy of note in their own right.

36.2 THE INSTITUTIONALISATION OF THE AGED

36.2.1 The Aged :

In the absence of death, the ageing process cannot be avoided. But it affects different people in different ways. One person of advanced years may be sound of body and sound of mind. Another person may be of lesser years but gravely affected physically or mentally or both.

Whereas the one may be able adequately to care for herself, the other may require constant care and attention. Moreover, the one may show no signs of deteriorating, either physically or mentally, the other may show signs of rapid deterioration. Whereas the one may be self-sufficient and not in need of care, the other may be desperately in need of care, and left alone at her peril.

To say that a person is old when she has attained the age of sixty, or qualifies for an old age pension, or feels constrained to lay down the burdens of running a home, is to apply a fallacious test.

It is recommended that age alone be not the test for determining whether a person is aged in terms of putting the institutionalization process into effect, but rather whether the nature and effects of the ageing process have reached the stage that specialised care is advocated. Where this test is applied, the process of institutionalization becomes logical, significant and imperative.

36.2.2 Institutionalisation :

Institutionalisation must not be seen as an event that occurs at a particular point in time or at a particular stage of life. It must be seen as a process which takes place over a period of time. It follows a natural progression. It has a starting point and a culmination. The culmination need not be considered but what is important is the starting point. And this need not be a single event. It is more likely to be the coming together of a number of events.

One is the state or condition of a person. This, in itself, may incorporate a number of considerations such as the physical state of a person, or her mental state. But whether physical or mental, it is indicative of a state of affairs which is other than normal. That, in itself, is, however, insufficient to set in motion the process of institutionalization.

What is recommended is that when three elements combine with each other the stage is set for the setting into motion of the institutionalization process. One is the state or condition of the person concerned which is referred to as 'other than normal'. The second is an inability on the part of the person to cope with a prevailing situation. The third is the need for specialised care to enable the person to continue with the process of living.

The nature and function of the institutionalisation process does not encompass these three elements alone. It goes much wider. It embraces the relocation of a person from one situation with which she may have very strong emotional and sentimental ties to another situation which is unknown, uncertain and obscure. Moreover, it may be contrary to her wishes and pleasure. Indeed, it may give rise to an antagonistic attitude and conduct.

It is accordingly recommended that the process of institutionalisation be accompanied by appropriate counselling to enable the person to adapt and adjust to her change in situation. There is little doubt that the move from the erstwhile residential home to an institution can be traumatic and all efforts must be made to alleviate the trauma. It is also recommended that the institutionalisation process be not terminated with the relocation in the institution but that it be followed by a period of intense and sympathetic attention to enable the resident to settle-in to her new surroundings.

36.2.2.1 The Institution

The role and function fulfilled by the institution cannot be overemphasized. It is the new home of the resident. It is here that, in all probability, she will live out the remainder of her days. It can be a source of pleasure; it can be a source of aggravation. It must be a place where she will be happy and it must be a place which will improve the quality of her life.

It is recommended that, if she is able, the resident shares in the selection of the institution which is to be her 'home'. This means that its physical structure must be attractive, practical and facilitative.

It is recommended that observations are not limited to the physical structure of the institution but that careful enquiry be made concerning the social structure, as these are the people with whom the resident will be mixing and engaging in social contact. An inadequate, haphazard, and disjointed social structure can only bode ill for the resident and cause her aggravation and distress.

However adequate may be the social structure, it must perform a social function which is efficient and acceptable. **It is recommended that the sum total of this function be probed and scrutinized to satisfy the inquiry as to whether it will improve the quality of life of the resident.**

36.2.2.2 **Finances**

The importance of finances manifests itself in every aspect of the institution; its initiation and commencement, its development, extension and upkeep, its operation. The point is so obvious that further elaboration is unnecessary. What is necessary is to advance sound recommendations to ensure that the institution has a solid financial basis, for without it its prospects of survival and success are remote.

It is recommended that in the management of its finances the institution strives to make itself as financially independent as possible. For as long as it relies, in the main, upon subsidization by the State, it makes itself vulnerable. The recommendation is not easy of attainment and involves the adoption of a sound financial policy. This means more than just being able to meet expenses with income. Indeed, it means more than merely having a healthy income, as this, with the passage of time, diminishes by reason of the ravages of inflation. What is required is a financial policy which provides for income as well as capital growth which can provide for a hedge against inflation.

It is also recommended that the management of finances be entrusted to worthy and skilful personnel who possess the knowledge and expertise to be able successfully to manage the financial assets. This, in turn, means more than the preparation, presentation and approval of an annually audited set of financial statements, but the preparation of a realistic and properly prepared budget which is monitored at frequent and regular intervals to assess and determine expenditure against income in the light of the budget. In other words, a watchful eye must constantly be kept upon expenditure against income. Moreover, a similar watchful eye must be kept on stocks and stores, and other areas of possible wastefulness, leakage and loss.

It is recommended that institutions avail themselves of all possible sources of revenue to compensate them reasonably for the services they perform. Comment is limited to innovative sources of income and does not include the usual and accepted means of fundraising. One relates to the limited admission of economic residents (at a higher fee) to institutions which cater in the main for sub-economic residents. The Department permits sub-economic institutions to admit a number constituting 40% of their occupancy of economic residents. These residents pay more but receive the same benefits and services rendered to sub-economic residents. In so doing, they effectively subsidize the sub-economic residents in a sum which can be substantial. The second relates to families contributing between them a sum which equals the shortfall between the budgeted cost to keep a resident, and the sum received by way of pension and subsidy. The resident (assisted by family members) effectively pays her way, thus making it possible for the institution to care for the indigent and those unable to pay the full sum of the budgeted cost to keep a resident. The third is novel and needs investigation. It relates to the possibility of a person proposing for insurance cover to ensure the risk of institutionalization at a particular age against the payment of a premium during her earlier years.

36.2.2.3 The Resident

The central feature of the institutionalization process is the resident. It is she who manifests a deterioration in her physical or mental state; it is she who finds herself incapable of handling a prevailing situation; it is she who is in need of care. Her family knows it, her friends know it, but does she know it? More often than not, she does not know it, or, if she does, she is not prepared, or able, to recognize it. Indeed, it is often the case

that when the subject of institutionalization is raised, even in the most subtle of terms, it is met with anger, objection and disgust. Moreover, where families or family members proceed to have a resident institutionalised (against her will) it is often met with the most violent reaction, or, at least, vehement opposition. How is the family to deal with this situation?

It is recommended that the resident be allowed to play a larger part in the institutionalisation process, especially where her condition is such that she is able to appreciate what is going on, and what the benefits and advantages of the institutionalization process are. The matter must not be left to the last moment but should be introduced intelligently and with sympathy and understanding. It must be accepted that the process may give rise to trauma, distress and upset. **Accordingly, it is recommended that that kindness and gentleness be demonstrated and that appropriate counselling be offered to assist the resident to accept, adapt and adjust to the change in her situation.**

36.2.2.4 The Family

The family has various roles and functions to play in the institutionalization process. These roles and functions are played out in the pre-institutionalisation situation, throughout the period of institutionalisation, and in the post-institutionalisation situation. They may be pleasant. They may be unpleasant. It depends upon the attitude demonstrated by the resident.

Whatever the attitude demonstrated by the resident **it is recommended that the family, readily and willingly, make themselves available to meet the varying needs of the resident.** They are the closest to her and she 'belongs' to them. They must be close at hand; they must be regular in their visitation; and they must demonstrate a continuous care and concern. Institutionalisation does not relieve them of their familial closeness and duty; nor does it involve a substitution of responsibility from the family to the Home. The family must be acutely aware of her physical, material and emotional needs, and must be ready and available to attend to them.

Institutionalisation does not spell the demise of the family. The family must not permit this to occur. **It is recommended that the family does all in its power to maintain the family structure with the resident as an integral and vital part of it.**

The family must always be part of the resident's life and the resident must always be made to feel part of the family. They must fully engage in her life and permit her to engage in the life of the family.

36.2.2.5 Study and Research

It is recommended that institutions of learning encourage study and research into an understanding of the needs of the aged in the context of institutionalisation. There are countless families who are facing the problem of institutionalization and who do not know to whom to turn for advice, guidance and help. There are many people who must face the reality of institutionalization and who are incapable of coping with the situation. To whom must they turn for assistance? There are residents who for prolonged periods see neither family nor friends. Is the need for visitation addressed in educational courses?

It is recommended that institutions of learning offer courses and advice to people dealing with the problem of institutionalization by way of summer school lectures, or limited period courses, or public addresses.

36.3 THE IMPORTANCE OF VISITATION

36.3.1 Visitation :

Visitation involves engagement; engagement at various levels; engagement within the ambit of various intensities; and engagement in accordance with various emotions. The engagement may be brief and superficial; it may be deep and meaningful; it may be jovial and friendly; it may be confrontational and antagonistic. There is a detestable aspect to engagement but there is also an admirable aspect to it. Fortunately, while visitation embraces both aspects, it is the admirable aspect that predominates. This is to be lauded as institutionalization, inexplicably, frequently manifests itself in isolation. There is a tendency among elderly ladies to avoid crowds and groups and to satisfy themselves with their own company. At the same time they are happy to welcome the visitor. Indeed, they look forward to acts of visitation. Visits from family members, visits from friends, visits from administrative personnel, and visits from the specialised visitor.

It is recommended that family and friends be urged and exhorted to visit the resident as frequently as possible, and not just sporadically. It is further recommended that family and friends make a special effort to make the visits as cordial and congenial as possible. Moreover, the visit should be meaningful and constructive. Finally, it is recommended that confrontation and conflict be avoided, so that the visit might enhance the quality of life of the resident and not detract from it.

36.3.2 Importance :

The importance of any occurrence or event is judged by varying criteria. Importance may be attached to one event and not to another. Likewise, one person may regard one event as important, while another may regard the same event as unimportant. It all depends upon the person's point of view.

It is recommended that the importance of visitation be measured, in the first place, by the need that manifests itself among elderly ladies for visitation.

36.3.2.1 Need

Loneliness and isolation in the life of any person is not to be commended. But there are other considerations in the lives of the elderly. There is the passage of time that has passed. There is the recurrent backward look. There is the separation from family and friends. There are the memories of years gone by. There is the increasing frailty of the advancing years. There are the worries, concerns and fears that need to be shared with someone. There are the longings for expressions of love and affection. There are the desires to be part of a family of which she was the Matriarch and the prominent figure.

It is recommended that in determining the importance of visiting the aged, greater regard be had to the wide variety of needs of the elderly for frequent and constant acts of visitation, and the ability of visitors to meet these needs by tender, compassionate and regular acts of visitation.

It is recommended that the importance of visitation be measured, in the second place, by the benefits and advantages that are held out to the aged by frequent and constant acts of visitation.

36.3.2.2 Benefits and Advantages

Effective visitation means frequent, continuous and regular personal contact. It means the manifestation of genuine concern, interest and care. It means the supportive intervention into situations with which the resident is unable to cope. It means offering to the resident stability, certainty and security in a situation which is often distinctly fragile.

It is recommended that in determining the importance of visitation, greater regard be had to the benefits and advantages held out to the institutionalised resident, and the ability of visitors to improve the quality of life of the aged by acts of effective visitation.

It is recommended that the importance of visitation be measured, in the third place, by examining the reaction to and receptivity of the aged to frequent and continual acts of visitation.

36.3.2.3 Reaction and Receptivity

Where visitation is characterized by contact which is continuous and regular, where there is demonstrated a genuine concern for the condition of the resident, and where a real interest is taken in the affairs of the resident, attitudes of suspicion and reserve on the part of the resident are broken down, barriers are dispelled, and goodwill and candidness is built-up. The atmosphere becomes more relaxed, conversation on a

deeper and more meaningful basis begins to emerge, and there is an exchange of thoughts and ideas. A relationship based on mutual confidence, belief and trust manifests itself and genuine, cordial and kindly interaction occurs. The prospect of a visit gives rise to excitement and anticipation, and something to which the resident can look forward. Where there is conversation, communication and mutual confidence, visitation has reached a high and important level.

It is recommended that in determining the importance of visitation, regard be had to the reaction and receptivity of the institutionalised resident, and that if any negative elements present themselves, the nature of the acts of visitation be examined to determine the reason for the resident's negative attitude.

36.3.3 The Visitation Programme :

There are two main programmes of visitation. One is referred to as the 'normal or regular pattern' and the other is referred to as the 'specialised pattern' of visitation. Because of the importance of visitation, it is needful to examine these patterns briefly in order to determine how best the resident can be served by a visitation programme, and to make recommendations thereanent.

The 'normal or regular pattern' covers a wide variety of visitational activity. The spectrum reaches from weekday visits, at the one end, to very occasional and very irregular visits, at the other. Hovering somewhere in the middle are visits over the week-end which may be regular, or happen every now and then. It is difficult to determine a fixed and uniform pattern of 'normal or regular' visitation, other than to say that the situation is far from satisfactory and distinctly disturbing when regard is had to the residents' need for visitation.

It is recommended that family and friends be urged and exhorted to increase the occurrences and regularity of acts of visitation, to vary the pattern of visitation and the participants therein, to encourage greater engagement in visitation on the part of the resident, to strive for quality of contact and communication, rather than mere duration, to incorporate some aim or objective into the act of visitation, and, above all, to avoid confrontation, arguments and angry exchanges.

It is recommended that visitation be seen as a means to an end, and not an end in itself, namely, that whatever format the act of visitation may take, its directive or aim should be an improved quality of life for the resident.

The 'specialised pattern' of visitation is different to the 'normal or regular pattern' of visitation, in that, it is more intense, more concentrated and more regular. Moreover, it is directed at an improved quality of life for the aged and holds out benefits and advantages for them. It is built on a foundation of relationships; it arises out of volition and not duty; it expresses itself in constancy and regularity, and is not a ritual or a habit. Its prime objective is to make the visitational process worthwhile, that by the caring concern of the visitor for the welfare of the resident, her quality of life will be improved and enhanced.

It is recommended that careful thought and attention be given by the Home to the introduction of a 'specialised pattern' of visitation, thereby increasing the occurrences of visitation, the regularity of visitation, the duration of visitation, and the quality of visitation. At the heart of a 'specialised pattern' of visitation is a genuine concern for the personal welfare of the resident, and an honest interest in her quality of life and her surrounding circumstances.

36.4 THE ROLE OF THE SPECIALISED VISITOR

36.4.1 The Visitor :

Whatever else may be said concerning the characteristics and qualities required of the specialised visitor, it is less important than an intense concern for those who are elderly and an ability to identify with the aged. It is less important than nurturing a spirit of humility, a sensitive disposition, a quiet and gentle patience, and a sympathetic appreciation for a frail body and a wandering mind. It incorporates but does not overemphasise an ability to motivate the most lethargic of God's creation, perceive the imperceptible, manifest conscientiousness where hopelessness abounds, and evince intelligence where intelligent response is no longer possible.

The visitor must attain to heights which may be out of reach: he must have standing, personality, education and experience; he must possess system and organization, he must be able to analyse and decide; he must be people-orientated and socially-minded. He must act with authority and firmness but at the same time, be flexible and co-operative.

These are the pointers or indications of the requirements of a specialised visitor. **It is recommended that to achieve the desired objective men and women of the highest caliber be sought : men and women who have achieved rank status and position in their business or professional careers, are ready for retirement or who have retired and who are ready, willing and able to return to society some measure of what they have received from society.**

36.4.2 The Role of the Visitor :

The role of the visitor is no less demanding. Who will readily admit to gifts of inquiry to find out what is useful and constructive, to be able patiently to listen, to inform and to advise? Who will readily admit to being able to encourage, strengthen, comfort and uplift? Who possesses the resources to offer hope, peace and faith? Who, with a bright and intelligent mind, will be able to call upon and communicate with one whose memory is failing and whose recall is feeble? Who will tarry a while with someone whose only conversation relates to aches and pains?

The role of the visitor is very exacting in its claims. **It is recommended that the demands and claims required of the visitor do not cloud his vision or dampen his ardour.** The demands and claims are high. But so are the rewards.

36.4.3 Specialisation :

Specialisation implies, in the first place, an inner call to perform the specific function of specialised visitation. It arises out of a calling or vocation. It bears with it the characteristics of worthiness and excellence. Specialisation implies, in the second place, being set apart specifically for the role and function of visitation. The principal task of the specialised visitor, indeed, his vocation, is visitation. It is to visitation that he applies his time, skills and talents. Specialisation implies, in the third place, regularity and continuity on the part of the specialised visitor in his role of visitation. His good faith and genuineness arise out of the fact that his visits and contact with the residents, are not sporadic and infrequent. They are characterized by constancy and steadfastness.

It is recommended that the specialised visitor be separated to the task of specialised visitation and that his association with the management and administration be limited so as not to detract from his separated task.

36.5 CONCLUSION

The investigation has been completed. Conclusions have been drawn. Recommendations have been made. The work is submitted as an explicit examination of the subject: The Institutionalisation of the Aged; the importance of visitation, and the Role of the Specialised visitor.

SECTION I. ADDENDA

. BIBLIOGRAPHY

. ANNEXURES

A. Ladies Christian Home Constitution

B. Ladies Christian Home Rules of the Home

C. Press Cuttings

D. Visitation Chart

ADDENDA

- **BIBLIOGRAPHY**

- **ANNEXURES**

E. Ladies Christian Home Constitution

F. Ladies Christian Home Rules of the Home

G. Press Cuttings

H. Visitation Chart

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THE LADIES' CHRISTIAN HOME**CONSTITUTION****(AS APPROVED BY THE DEPARTMENT OF SOCIAL DEVELOPMENT****ON 5 APRIL 2001)****1. PREAMBLE**

In 1876 the LADIES' CHRISTIAN HOME (then known as The Christian Home for Aged and Indigent Ladies) was established in Cape Town. The purpose of the founders was to provide a Home for aged and indigent Ladies; such to be run on stated religious principles namely Evangelical, Protestant and non-sectarian. To this end buildings and premises were erected. The early vision never dimmed. The work of the Home has prospered; buildings and premises have been extended and increased; and the purpose for which the Home was founded has been enhanced.

Accepting the validity of the purpose for which the Home was founded and building on the sure foundations laid, but with the changing demands of the future in mind, it is considered necessary, for the proper and efficient management of the Home, to review, revise and amend the Rules and Regulations whereby the Home has hitherto been governed.

It is therefore determined that the Constitution whereby the Home will, subject to amendment from time to time as occasion demands, in the future be governed, shall be as hereinafter set forth.

2. MISSION STATEMENT

The Ladies' Christian Home has been an integral part of the City of Cape Town and its environs since 1876.

Its primary concern is for ladies who are elderly, infirm and needy; to respect their rights, to accord them dignity, to attend to their welfare, and to ensure their freedom from danger, care or fear.

It recognises the importance of material things and of humanistic concerns but its primary motivation is neither materialistic or humanistic. In all its endeavours it is motivated by a love for God, and an expression of that love in tender, compassionate, benevolent and charitable acts, for the benefit of the physical, mental and spiritual welfare of those for whom it cares.

Nor are its only concerns for the elderly, infirm and needy but for those whose task it is to minister to them, to serve, to help and to offer succour and aid. It believes that the welfare and security of the elderly, infirm and needy are best served by staff members whose own rights, dignity, and well-being are recognised, respected and advanced.

3. OBJECTS

In keeping with its Mission Statement and in amplification thereof, the objects of the Home shall be:-

- 3.1 to provide a home for elderly and needy person;
- 3.2 to provide for the sustenance, health and welfare of the residents of the Home;
- 3.3 to provide means whereby spiritual guidance, teaching and encouragement may be given to the residents of the Home; all such to be consistent with and supportive of the Mission Statement and in keeping with Evangelical, Protestant and non-sectarian principles;
- 3.4 to provide as far as is reasonably possible for the presentation of the gospel of salvation through faith in the Lord Jesus Christ.

4. MANAGEMENT

4.1 BOARD OF TRUSTEES

- 4.1.1 The management, government and general conduct of the

affairs of the Home shall vest in a Board of Trustees who shall exercise all powers necessary and requisite for carrying out the objects of the Home. Without derogating from the generality of the powers aforementioned, it is specifically determined that the Board of Trustees shall have the power to invest the capital resources of the Home in such manner as they may determine from time to time and to realise and re-invest such resources. Moreover, in the complete and absolute discretion of the Board of Trustees, they shall have the power to expend such resources upon the need of the Home.

4.1.2 As far as possible the Board of Trustees shall comprise:

4.1.2.1 Five persons elected in the manner set forth in Clause 5.1 (hereinafter referred to as Trustees);

4.1.2.2 One ex officio Trustee respectively appointed by each of the following Denominations, namely, Baptist, Dutch Reformed, Church of England in South Africa, Methodist and Presbyterian in the manner stipulated in Clause 5.1 (hereinafter referred to as ex officio Trustees),

which persons shall exercise the powers and functions of the Board of Trustees. Each Trustee shall subscribe to and accept the provisions of Clause 3.3 above and four Trustees shall constitute a quorum. When necessary, the Board will vote on issues. If the votes are equal on an issue, the Chairman will have a deciding vote.

4.1.3 One of the Trustees shall act as Chairman of the Board and each of the others shall respectively hold one or more of the following portfolios:-

4.1.3.1 Trustee in charge of the spiritual welfare of the Home whose task it shall be to oversee and co-ordinate the spiritual activities in the Home;

4.1.3.2 Trustee in charge of the Home's Finance and Investments and who, in liaison with the accountant shall, inter alia, compile annual budgets, monitor actual to budget performances, prepare projections, and monitor short and long term investment;

4.1.3.3 Trustee in charge of Household Affairs who, in liaison with the General Manager shall, inter alia, monitor day to day management of the Home, Staff, Union activities, maintenance, gardening, and generally be of assistance to the management of the Home;

4.1.3.4 Trustee in charge of legal matters whose task it shall be to assist the management of the Home, if and when a need arises.

In respect of each portfolio, and as circumstances dictate, there may be appointed a committee to assist in decision-making and implementation. Each such committee member shall be appointed by the Board of Trustees. As far as is reasonably possible such committee members shall be denominational representatives of the various Churches mentioned herein.

4.1.4 It shall be the function of the Chairman of the Board of Trustees to direct to the General Manager for implementation, all decisions of the Board of Trustees.

4.1.5 The Board of Trustees shall have power to employ professional secretaries and treasurers who shall not have a

seat on the Board of Trustees but may attend meetings of the Board at its pleasure.

4.2 GENERAL MANAGER

4.2.1 The Board of Trustees shall have power to appoint a General Manager for the purpose of managing the day-to-day affairs of the Home; to implement decisions of the Board of Trustees as conveyed to him by the Chairman; and to attend to the ordinary, normal and general activities of the Home.

4.2.2 The General Manger shall be responsible for the general welfare of the residents and all the activities conducted in the Home and shall be directly accountable to the Board of Trustees.

4.2.3 Without derogating from the generality of the aforementioned authority of the General Manager, it is specifically determined that the general management authority of the General Manager shall extend to the following spheres of the Home's operation:-

4.2.3.1 Frail care: the operation of the Frail Care Unit; the appointment, supervision and dismissal of staff; and the disciplining of such staff members.

4.2.3.2 Catering: the entire ambit of the catering operation, including the appointment, supervision and dismissal of staff; and the disciplining of any staff member.

4.2.3.3 House-keeping: the house-keeping operation, including appointment, supervision and dismissal of staff, that is, the Supervisor, domestic employees, the gardener, maintenance and laundry employees and the driver; and the disciplining of any staff member.

4.2.3.4 Accounting: the activities of the accounts department, including supervision and control over the accountant.

4.2.4 The General Manager shall prepare a monthly report and profit and loss account and submit same together with an Agenda at least one week before any ordinary meeting of the Board of Trustees.

4.2.5 Any appointment or dismissal of staff shall be done in liaison with the Trustee in charge of the relevant area of operation.

5. APPOINTMENTS

5.1 TRUSTEES

The Board of Trustees shall comprise all Trustees in good standing as at 1st January 1994 and ex officio one Trustee appointed by each of the following Denominations: the Baptist, the Dutch Reformed, the Church of England in South Africa, the Methodist and the Presbyterian. Such ex officio Trustees shall be nominated by the local body, presbytery or circle of the respective denominations. By "local" shall mean having jurisdiction over the churches of the respective denominations in the Western Cape. Thereafter, the appointment of any and all further and additional Trustees shall be:-

5.1.1 on the nomination by any interested person to the Chairman of the Board of Trustees who shall consider the nomination and if it meets with his approval, he shall place such nomination before the Board of Trustees. An appointment shall be made in accordance with a majority vote of such Board;

5.1.2 on the nomination of the Chairman or any member of the Board of Trustees to such Board who shall consider such

nomination, and determine any appointment in regard thereto by a majority vote of the Board.

Notwithstanding the aforementioned, the Board of Trustees may, by majority vote, and upon the nomination of any Trustee, appoint a Trustee for a limited period or for a particular purpose.

5.2 CHAIRMAN OF THE BOARD OF TRUSTEES

The Chairman of the Board of Trustees shall be such person who is Chairman as at 1st January 1994. Thereafter the appointment of a Chairman shall take place in the following manner:-

5.2.1 on the nomination in writing of any Trustee, which nomination shall be accepted in writing by the nominee; and

5.2.2 by majority vote of the Board of Trustees.

5.3 TRUSTEES' PORTFOLIOS

The appointment of a Trustee to a particular portfolio, as envisaged in Clause 4.1.3 hereof, shall be on the nomination of the Chairman of the Board of Trustees, acceptance by the nominee, and a majority vote of the members of the Board.

5.4 GENERAL MANAGER

The appointment of the General Manager shall be upon the nomination of the Chairman or any member of the Board of Trustees, and a majority vote of the Board. The General Manager shall be one who is in sympathy with and supportive of the general principles upon which the Home is structured.

6. ASSETS

6.1 All landed property and funds of the Home shall be vested in the

Trustees for the time being to be held in trust for the Home, subject to the rules and regulations set forth in this Constitution.

- 6.2 Subject to the provisions of Clause 12.1 hereof, banking accounts shall be opened in some approved banking institution, wherein shall be deposited all funds belonging or appertaining to the Home, save and except such funds as are invested in accordance with the powers of investment of the Trustees. All cheques drawn on the said bank shall be signed by two signatories authorised so to do by the Board of Trustees.
- 6.3 The Board of Trustees shall cause such books and accounts to be kept, as will show a clear record of all transactions in connection with the Home.
- 6.4
 - 6.4.1 Once every calendar year, and at a date determined by the Board of Trustees, there shall be laid before the Board an account of the income and expenditure of the Home for the period since the close of the last preceding account; and a statement of the assets and liabilities of the Home. For so long as the Home is subsidised by any Department of State, the annual accounting period shall conform with the requirements of that department.
 - 6.4.2 The account and statement aforementioned shall be examined and audited by auditors duly and properly appointed by the Board of Trustees.
- 6.5 All property and income of the Home shall be used solely in the furtherance of its objects or in payment in the ordinary course for goods supplied or services rendered. No property or income shall be transferred directly or indirectly in any manner whatsoever so as to profit any person other than by way of the payment in good faith of a reasonable remuneration or gratuity to any officer or employee of the Home for services actually rendered to it.

7. **MEETINGS**

7.1 As far as is practically possible, the Board of Trustees shall meet once every month to attend to the business of the Home. Proper minutes of the proceedings shall be kept.

7.2 An annual general meeting of the Board of Trustees shall be held, not later than six months after conclusion of the immediately preceding financial year. Such meeting shall be open to all residents and interested parties (with the approval of the Chairman) to attend. At such annual general meeting there shall be tabled:-

7.2.1 the account and statement hereinabove referred to;

7.2.2 a report as to the work of the preceding financial year and the condition of the Home generally.

Residents and approved interested parties shall be entitled to comment upon or discuss any matter which is relevant to the affairs of the Home.

7.3 Members of the Board of Trustees will, at the first meeting of every year, be advised of the dates of each meeting to be held in the course of the year, and 14 calendar days notice will be given to each member in advance of each meeting.

7.4 The financial year of the Ladies Christian Homes ends 31 March.

8. **ADMISSIONS**

8.1 Applications for admission to the Home shall be addressed to the General Manager who, together with such persons as may be approved by the Board of Trustees, shall consider such application for admission and determine whether such applicant shall be admitted to the Home as a resident.

- 8.2 Preference shall be given, as far as possible, to applicants who are needy. If an applicant, at the time of admission or at a later date is able to contribute to her support, she shall be subject to such requirements in this respect as may be laid down by the Board of Trustees in each particular case, on the recommendation of the General Manager. Applicants shall be obliged to disclose all details of their financial position, and the Board of Trustees, in the event of such details not being fully disclosed shall have power, during residence or from the Estate in the event of decease, of charging and claiming rates for board and lodging as are in keeping with the applicant's actual financial position, regard being had to the obligations of the Board of the public of Cape Town, to whom it appeals for financial support for the Home.
- 8.3 Applicants for admission shall not be subject to any denominational test but will have to satisfy the person or persons envisaged in preceding sub-clause 8.1 hereof as to the worthiness of their character and suitability for acceptance.
- 8.4 Successful applicants shall be subject to the Rules and Regulations of the Home. They will be expected to attend family worship, and the religious services held in the Home from time to time, which religious services shall be open to all residents of whatever denomination.

9. **MISCELLANEOUS**

9.1 **LOCUS STANDI**

All legal proceedings shall be instituted and defended in the name of the Trustees for the time being, and all powers to sue or defend shall be signed by not less than two of them duly authorised thereto by the Board of Trustees.

No Trustee, ex officio Trustee or any of the denominations hereinbefore recited, shall be liable for the debts or engagements made, contracted or entered into by or on behalf of the Home.

9.2 WELFARE COMMITTEE

There shall be formed a committee, to be known as the WELFARE COMMITTEE, to address the needs of individual residents and the Home as a whole for social and recreational purposes. This committee shall operate under the supervision and control of the General Manager and shall comprise such members as are approved by the Board of Trustees and, ex officio one member appointed by each of the following Denominations: The Baptist, the Dutch Reformed, the Church of England in South Africa, the Methodist and the Presbyterian.

9.3 STAFF

Staff members shall not be subject to any denominational test but will have to satisfy the General Manager of their religious beliefs and the worthiness of their character. The religious belief of any staff member shall not be such as to be likely to occasion dissension within the Home whether in relation to other staff or in relation to residents or management.

10. DISSOLUTION

- 10.1 The Home as an association may be dissolved upon the 2/3rds majority decision of the Board of Trustees; such decision to be confirmed at a further meeting properly convened.
- 10.2 If upon dissolution of the Home there remain any assets whatsoever after the satisfaction of all its debts and liabilities, such assets shall not be paid to or distributed among any of its members or trustees, but shall be transferred to such other charitable, ecclesiastical or educational institution within the Republic of South Africa, which are

themselves exempt from income tax and donations tax, preferably having similar aims and objects and which are authorised to collect contributions in terms of the Non Profit Organisations Act, 1997 (Act 71 of 1997), as may be decided by the members or trustees at the General Meeting at which it was decided to dissolve the Home or, in default of such decision, as may be decided by the Director of Non Profit Organisations.

11. AMENDMENTS

11.1 These Rules and Regulations shall be subject to alteration, modification, or amendment in accordance with an appropriate resolution by the Board of Trustees. due and proper notice of such alteration, modification, or amendment shall be given. It shall be debated and discussed at the following meeting of the Board of Trustees, but only resolved at a further meeting.

11.2 Copies of all amendments to the constitution shall be submitted to the Commissioner for Inland Revenue.

12. GENERAL


12.1 All monies received on behalf of the Home shall be deposited in the name of the Home in a bank account with a registered commercial bank chosen by the Trustees and any such funds available for investment may only be invested with registered financial institutions as defined in Section 1 of the Financial Institutions (Investment of Funds) Act, 1984, and in securities listed on a licensed stock exchange as defined in the Stock Exchanges Control Act, 1985 (Act No. 1 of 1985).

12.2 The Home shall not have the power to carry on any business, including, inter alia, ordinary trading operations in the commercial sense, speculative transactions, dividend stripping activities as well as the letting of property on a systematic or regular basis.

SIGNED AT CAPE TOWN ON THIS 26 DAY OF JULY 2001,
THE BOARD OF TRUSTEES HAVING UNANIMOUSLY APPROVED THIS AMENDED
CONSTITUTION ON 26 JUNE 2001.



DR. C.B. PREST SC
CHAIRMAN



E.M. RABY
GENERAL MANAGER



H. FARROW
TREASURER

ANNEXURE

LADIES CHRISTIAN HOMERULES OF THE HOME

1. The aim of the Board of Trustees, General Manager and Staff is to attempt, as far as possible to make the residents feel that they have a new home. It is the wish of the Board to create and maintain a pleasant atmosphere in the Home. For this reason it is expected of each resident to conduct herself in such a manner that life will be a pleasure to them and to others.
2. The General Manager has complete authority and supervision over the home and acts on the instructions of the Board. The residents are expected to respect her as well as other members of the staff and not to interfere with their duties.
- X 3. Residents shall provide their own linen and shall replenish the same as and when necessary. Upon death of a Resident all furniture and all linen brought into the Home shall become the sole property of the Home. By "linen" is meant sheets, towels, pillow-cases, blankets and bedspreads. Residents must also provide curtains for their rooms, and replace them when necessary.
- X 4. Religious Devotion
Residents are required to attend the service at 9.30 on Tuesday mornings at the Home.
- X 5. Tidying of Rooms
Residents, other than invalids, must dust their own rooms and make their beds. Once a week the maids sweep and polish the floors, but residents must do the dusting themselves.
- X 6. Laundry
Small items may be washed in the tubs in the bathrooms and hung in the drying-yard, but the Home provides laundry services for linen and large items. 10 P.M.
7. Meals
As only three meals are provided, X it will be necessary for each resident to provide cup and saucer, etc. for teas. Hot water is provided from kettles on each floor. X No cooking shall be allowed in the rooms. The hours of meal-times are indicated on the notice board.
8. Absence from Home
Residents must advise the Catering Manager in good time when they expect to be absent for meals, or when they expect to be home late at night. At 10 p.m. the doors leading outside are locked and thereafter access is only by prearrangement with the staff. Should a Resident wish to sleep out, she must sign the book provided for the purpose and she must leave the address to which she is going.
9. Vacation
One month's vacation is permitted per year. Should a resident wish to be away from the Home for a total period of more than 31 days in the calendar year, she must obtain special permission from the General Manager.

X = NOT APPLICABLE TO FAMIL CARE RESIDENTS

ANNEXURE (continued)

10. Doctors

Should a Resident wish her own Doctor to visit her in the Home, she must first ask permission of the Senior Sister before calling him. On no account must a Resident call the Doctor for another lady in the Home without the Senior Sister's permission. Permission must also be obtained before taking a lady to see a Doctor at his rooms.

11. Resting Hours

Residents are encouraged to rest between 1 p m and 3 p m daily. No unnecessary noise may be made early in the morning or afternoon or late at night while others are resting.

12. Finance

Residents are obliged annually, or when requested to do so by the Board, to furnish documentary proof of their financial position. In the event of incorrect returns being rendered the shortage may be recovered retrospective.

Board and lodging is payable on the day that Government Pensions are paid. Persons who have other source of income must make the necessary arrangements to ensure that their board and lodging is paid on the 1st of each month.

No reduction of board and lodging is granted for periods during which occupants are away on vacation.

One month's notice to vacate must be given on the 1st of the month.

13. Changing of Rooms

When the General Manager decides that a Resident shall be moved from one room to another, that decision shall be final.

14. Loss of Valuables

The Home will not accept responsibility for the loss of money, jewellery or other valuables belonging to Residents.

15. Liquor and Smoking

No liquor and no smoking shall be allowed in the Home.

16. Animals and Firearms

Residents are not allowed to keep animals as pets; nor may firearms or dangerous weapons be kept in the rooms.

17. Tipping

Tipping of staff is prohibited.

18. Electrical Appliances

Electric irons, hotplates and kettles are not allowed in the rooms except by special permission of the General Manager.

19. Noise

Radios and television sets are to be tuned to a volume that will not disturb others. In the case of hearing impediment earphones should be used.

ANNEXURE (continued)

20. Cleanliness

Bathrooms and toilets should always be left in a spotless condition. Bedrooms should always be kept tidy.

21. Personal Neatness

Residents are expected to be neatly dressed and clean when leaving their rooms or when going out. Hair in curlers (rollers) and the wearing of aprons is not acceptable in the dining room or lounges.

Failing Health

Should a resident's state of health deteriorate to such a degree that she requires hospital treatment, then she will be hospitalized. The decision in this regard of the Senior Sister supported by two Doctors shall be final.

23. Funeral Policy

Residents are required to join the Home's Burial Scheme and the relevant amount must be paid when you enter the Home.

24. Last Will and Testament

It is incumbent on residents to furnish the names and addresses of persons with whom their wills are lodged. Wills can be left in the Home's safe.

25. Visit Hours - Frail Care Unit

10.00 a m to 11.00 a m
3.00 p m to 4.00 p m
4.45 p m to 7.00 p m

26. The Board of Trustees reserves the right at any time to amend or supplement these rules.

27. A resident who becomes ill and who is in need of nursing care will, at the discretion of the General Manager and Senior Sister, be transferred to the Frail Care Unit until such time as she is well and able to bath and dress herself and go to the diningroom for her meals.

28. The Board of Trustees reserves the right to transfer any resident from her room to the Frail Care Unit when, in the opinion of the General Manager and Senior Sister, her failing health and inability to care for herself makes this advisable.

Golden dream fades for aged

CAPE ARGUS 28/10/99
City old age home may have to close as state subsidies shrink

HELEN BAMFORD
STAFF REPORTER

Huis Zonnekus, a home for the aged in Milnerton, is one of 39 old age homes run by the Dutch Reformed Church that may be forced to close because of dwindling government subsidies.

The closure would leave thousands of elderly people destitute. Many have no families of their own.

Council for the Aged director Helena van Niekerk said old age homes all over the Western Cape were having to make do with less money and good staff because of low salaries and often had to rely on untrained nurse aids.

"With the Government subsidy predominantly covering frail care, many homes are only accepting people needing this type of service. They need 24-hour care but this is often not possible," she said.

Johan Smit, spokesman for the church's department of social services and poverty relief, said the department was working towards parity. Many old age homes in poorer areas managed to survive on Government subsidies. "People have to realise that our resources are finite and these days they have to go round to all people."

Tielman Krige, vice-chairman of the board at Huis Zonnekus, said the home could not be run as it should

be because of a shortage of money.

More nursing staff was needed to offer a more personalised service but budget constraints prohibited this. "We can't even cover our costs but we are doing the very best we can. We have been waiting for R80 000 in subsidies which they keep promising we'll get but we never do," said Mr Krige.

"It's almost impossible to give personal attention but we do the utmost with the money we have."

He said the only alternative was for people to go into expensive private homes.

Jaypee Malherbe said his mother Margreta, 90, had fallen "countless times" during the time she had been a resident at Huis Zonnekus. In her latest fall Mrs Malherbe split her forehead open, cut her finger and bruised an eye and her face when she fell out of bed.

Mr Malherbe said he was so upset about his mother's injuries that he was considering laying charges of abuse and neglect against the staff. He had taken his mother out of the home.

But sister-in-charge Louise van Niekerk said it was not unusual for elderly people to fall because they were frail and often unsteady.

"Some fall when they get out of bed too quickly and their blood pressure drops, others trip over things or slip. It's impossible to give personal



Injured: Margreta Malherbe, 90, who rolled out of bed at Huis Zonnekus

attention because we only have three nurses for 96 people but they do the best they can and are very committed."

Sister Van Niekerk said she respected Mr Malherbe for being so protective of his mother but that on occasion he was unreasonable in his expectations of what the facility

could offer.

"On the night Mrs Malherbe fell a nurse had checked on her minutes before and she was lying in bed. She then heard a thud and found Mrs Malherbe had rolled out of bed, knocking her head as she fell."

Sister Van Niekerk said Mrs Malherbe was very weak after a stroke a few years ago.

"She's a loveable lady and laughs a lot. She's always seemed happy here."

Dominee Willie van der Merwe, chief executive officer of the Dutch Reformed Church's welfare commission, said closing down old age homes wasn't on the agenda yet.

He said the church-managed old age homes, which catered for about 4 500 people, were expected to operate on the same subsidy scale as in the 1992/93 financial year.

Most homes were in a similar predicament.

"We're getting less income but our expenditure is always increasing and we can't put the tariffs up because many of our residents live on fixed amounts."

Mr Van der Merwe said the Department of Welfare's plan to subsidise only the frail elderly and those living on sub-economic incomes could further jeopardise the future of the church-run homes. "The bottom line is that if we don't have money we will have to close."

Now it's grief counselling for shell-shocked Kivi fans

Palmerston North, New Zealand - Massey University is offering grief counselling advice for dejected rugby fans in the wake of the All Blacks' crushing defeats in the World Cup.

The Palmerston North campus, believing the defeats may have a far reaching effect on the nation's psyche, has released a list of five experts who may be able to help those struggling to cope with this major national disaster.

The group of lecturers and professors is

among a host of experts "ready to answer questions with authority and from a number of different perspectives".

Professor Gary Hermansson, recently appointed sports psychologist to the New Zealand Olympic Games Team for the Sydney Games, has been listed as an expert who can "analyse the plight of the players, individually and as a team, and the outpouring of collective grief".

Sport management lecturer and sports psy-

chologist Trish Bradbury looks at the responsibilities of the NZ Rugby Football Union and the shock suffered by team members.

Dr Graeme Bassett, of the School of English and Media Studies, saw the defeat as a major blow to the self-esteem of a large segment of the population.

"It is as if the team represents the self-worth of the country."

Dr Lynne Star, from the university's School of Sociology and Women's Studies said she

could see a strong connection between the old festival of carnival and this country's favourite pastime.

"Carnival was a time when all classes of society would get together to play a rough version of football, kicking a pig's bladder around. It was a time when normally offensive behaviour was condoned: fornicating, fighting, bawling or attacking groups like gypsies, ugly women and foreigners," she said. - Sapa NZPA

Blah Bar survivors offered counselling, gay alliance lashes at terrorism

People traumatised by the bomb blast which ripped through the Blah Bar in Green Point at the weekend could seek counselling via two Cape Town organisations, the co-owner of the bar, Glynis Delaney, said yesterday.

Client service manager of the Triangle project, Glenn, is available on (021)

448-3812 for face-to-face counselling while the lesbian helpline (021) 422-2500 is also standing by.

A fund has been opened for the victims of the blast, which left nine people injured.

People wishing to contribute to the fund should make cheques payable

"Victims of the Blah Bomb Blast", Standard Bank, Grassy Park branch, account number 374-027-323, branch code 02820917.

The Gay and Lesbian Alliance (GLA) yesterday condemned the attack.

"Acts of terrorism against any

peaceful section of our community are also directed against the spirit of our Constitution," GLA said, adding it was convinced the authorities would act with no mercy in this apparent hate crime.

"Old-style anti-democratic actions against the peaceful section of our com-

munity is not going to succeed, as this time round we enjoy the power of our Constitution and the support of the ANC-led government."

GLA also said it strongly supported Cape Town Tourism manager Sheryl Ozinsky in her efforts to promote gay tourism in the Western Cape. - Sapa

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